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# **Gender Relations in a Dementia Care Setting**

**A thesis submitted to Middlesex University in partial fulfilment of the  
requirements for the degree of Doctor of Philosophy**

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## **ABSTRACT**

### Gender Relations in a Dementia Care Setting

This study has been motivated by the need to better understand gender relations in dementia care. Across time and place, gender has been shown to be a fundamental relationship of social organisation. As such, it is hypothesised that gender is likely to have a similarly patterning influence upon relations in residential dementia care. It is argued there is a need to consider the person with dementia as a gendered (and sexual) individual. The study considers the ways that gender produces experiences of a care setting, and how gender is configured by the discourses and practices that characterise dementia care. A dementia care setting also provides a standpoint from which to problematise gender as a widely used but politically sensitive discursive category.

The study has been undertaken within the context of a wider investigation of communication and dementia care: Alzheimer's type dementia: Communication Patterns and their Consequences for Effective Care (CPCEC). The research was carried out exclusively within care facilities owned and run by Jewish Care, a voluntary sector organisation offering care and support to the Jewish community.

The study takes an exploratory approach to gender relations and is organised according to two main themes. In the first section, attention is paid to hierarchies of identity. A brief review of the historical and socio-political context is offered in order to trace certain themes and key constructions in welfare policy and provision from this wider context to the local settings of the care homes under investigation. It is argued that identity and social experience underpin relationships to a hegemonic perspective in care settings for both residents and staff.

The second section is organised according to the theme of interactions. The study makes a contribution to an understanding of care as a situated practice. Drawing upon video data, the dynamic quality of care is underscored and this provides a basis for a

conceptualisation of care as an interactive social activity. Gender's connections to other aspects of identity and social experience are also encompassed as another form of interaction. Particular consideration is given to the interconnectedness of gender and sexuality and it is shown that gender shapes the interpretation of sexual expression within dementia care.

The dearth of existing research into gender relations and dementia care makes this a unique piece of research, which has more than local implications. Rather, it fills a silence in this area, on both a theoretical and practical level, and promotes both knowledge (theory) and methodological matters to a wide audience. The study holds relevance to formal care settings and similar establishments regarding gender and social relations and beyond, as it adds yet another piece to the 'puzzle' of gender relations in society.



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# **GENDER RELATIONS IN A DEMENTIA CARE SETTING**

## **CONTENTS:**

<b>1. INTRODUCTION</b>	<b>Page 1.</b>
<b>2. PERSPECTIVES</b>	<b>Page 7.</b>
<b>3. SCOPE AND METHODS</b>	<b>Page 27.</b>
- Aims	Page 27.
- Analysis	Page 28.
- Ethics	Page 32.
- Methods	Page 33.
<b>4. HIERARCHIES OF IDENTITY – PART ONE</b>	<b>Page 59.</b>
<b>History and Context</b>	<b>Page 59.</b>
- Constructions of Jewish History	Page 62.
- Policy and Legislation	Page 73.
- Organisational Representations	Page 82.
<b>5. LIVES IN CARE</b>	<b>Page 87.</b>
- The Care Regime	Page 87.
<b>Hierarchies in Care</b>	<b>Page 97.</b>
- Gender Distribution	Page 97.
- Identity, Status and Context	Page 101.
- Hierarchy and Sexuality	Page 105.
<b>6. HIERARCHIES OF IDENTITY – PART TWO</b>	<b>Page 111.</b>
- Typologies of Care	Page 111.
- Perspectives on Care	Page 115.
- Gender and Dementia Care	Page 120.
- Dichotomies	Page 125.
<b>7. INTERACTIONS – INTRODUCTORY ANALYSIS</b>	<b>Page 159.</b>
- Analysis One: Communication	Page 159.
- Analysis Two: Gender and Communication	Page 165.

<b>8. INTERACTIONS – PART ONE</b>	<b>Page 178.</b>
<b>Speaking Care</b>	<b>Page 181.</b>
- The Care Dynamic – Part One	Page 190.
<b>Feeling Care</b>	Page 198.
<b>Doing Care</b>	Page 210.
- The Care Dynamic – Part Two	Page 222.
<b>9. INTERACTIONS – PART TWO</b>	<b>Page 228.</b>
<b>Identity in Place – Part One</b>	<b>Page 229.</b>
- Dimensions of Home	Page 229.
<b>Identity in Place – Part Two</b>	<b>Page 237.</b>
- Identity and Interaction	Page 242.
<b>Identity in Place – Part Three</b>	<b>Page 260.</b>
- The Construction of Sexuality in Care	Page 260.
<b>10. CONCLUSION</b>	<b>Page 282.</b>
- Overview	Page 282.
- Influences	Page 285.
- Organising Themes	Page 290.
- A Snapshot of Dementia Care	Page 300.
<b>APPENDICES</b>	<b>Page 311.</b>
<b>BIBLIOGRAPHY</b>	<b>Page 327.</b>



## 1. INTRODUCTION

What is dementia?

For a study conducted within a dementia care setting, it seems a useful beginning to attempt a definition of the condition itself. There are however, various ways in which to know dementia and these differing, arguably competing, versions are usefully understood as hierarchically arranged. An outcome of this ordering is that certain constructions of dementia appear to have greater authority, if not a greater power to explain. As systems of representation they organise an understanding of the condition and approaches to the care and support of people with dementia.

A biomedical narrative of dementia centres upon the brain. Certain changes to the brain are considered the defining characteristics of the disease. In Alzheimer's such changes include the presence of neurofibrillary tangles and senile plaques caused by a build-up of a type of protein known as beta-amyloid. It is argued that these lesions on the brain cause changes to personality and behaviour (defined as disease symptoms) and a progressive deterioration in various aspects of cognitive functioning. The linear causal relationship between lesions and symptoms underpins representations of a dementia 'pathway' depicted as a steady downward slope, from onset to death.

Alzheimer's is only confirmed by the post-mortem detection of plaques and tangles in the brain. However, advances in visualising technologies (Haraway 1991) affirm the significance of the brain, through mapping its changed appearance. Ways of seeing construct the object of the gaze. Thus, scanning technology generates representations of the diseased brain, thereby anchoring dementia physiologically. A number of drugs (donepezil, rivastigmine and galanthamine) have been shown to influence the progression of Alzheimer's type dementia, albeit for time limited periods. A further range of neuroleptic medications may be employed to manage symptoms commonly associated with the disease. As yet, there is no cure, nor any preventative medical interventions.



### Certainty:

Diagnosis relies upon the identification of a number of pre-defined symptoms. A variety of diagnostic tools are available for assessment, and these may be supplemented by the use of brain scans if uncertainty persists. Through cognitive testing, scales are applied from which scores are generated. As these scores change over time so a trajectory is plotted. This system of scoring signals not only the presence of dementia but is argued to offer an insight into the severity of impairment. Testing facilitates classification, with categories indicating disease stages. This system of classification appears largely unfettered by intervening social and environmental variables. Thus, diagnosis is a constructive procedure as well as a means of detection.

It has been argued that the purpose of diagnosis is to inform patients accurately about what is wrong with them, what can be done about it and what the future holds (McKeith and Fairbairn 2001). However, the social consequences of diagnosis are of less concern to these procedures. What impact testing and diagnosis has upon individuals and whether and in what ways the attribution of a diagnosis serves to improve quality of life, are questions that lie outside the scope of cognitive assessments. Similarly, there seems to be less concern to inform people about how the diagnosis of dementia functions as a label, with implications for their lives distinct from effects of the disease.

### Uncertainty:

Attempts have been made to identify common features and to highlight core aspects of dementia in order to model the disease. Despite such endeavours a tension exists between discursive constructions of dementia and the spectrum of experiences the condition is reported to produce. An early study by Gubrium (1987) offered an account of the contrasting and sometimes contradictory (proxy) reports of the experience of dementia by family carers attending support groups. The notion of a disease pathway with discrete stages was found to poorly encapsulate such heterogeneity, highlighting the fragile and contested status of a biomedical model.



Gubrium argues the prominence of a biomedical model is tied to the wider status and appeal of scientific discourses. Yet, such a model appears neither fully representative of lived experience nor adequately equipped with the necessary tools by which to delineate a complex and individualised phenomenon. Order and coherence thereby emerge as products of elision.

Re-invention:

According to a psychosocial approach to dementia (Kitwood 1990, 1995 and 1997 and Kitwood and Bredin 1991, 1992a, 1992b) the effect of neurological impairment is one component of a wider disease experience, given the interaction with an individual's personality, biography, physical health and the quality of supportive relationships. Kitwood has challenged the physiological narrative of medical science for failing to take account of how the quality of care influences experiences of dementia. It is argued that a 'malignant social psychology' can actively contribute to deterioration. By contrast, appropriate care represents a major source of support to an increasingly disrupted sense of self or 'Personhood'.

Recognition of the heterogeneous experiences of dementia informs a psychosocial approach, underpinning demands that knowledge of each individual is generated in order that appropriate care and support may be tailored. This has been called a 'person-centred' approach. Integral to a psychosocial account is therefore a protocol for how to undertake care. Despite the relevance and applicability of such an approach its presence as an organising system of knowledge and practice in dementia care settings has yet to be demonstrated (Packer 2000, Sheard 2004).

The apparently slow uptake of person-centred care has been attributed to a number of factors. Bond (1992) has argued that the medicalisation of dementia signals the exercise of expert control. The medical profession secures a mandate to provide treatment through defining behaviour as a medical problem. As such, a biomedical model remains the



primary resource for the logic of care. It is the dominant system of representation (discourse), through which the identity of a person with dementia is constructed and upheld in care settings.

Despite an emphasis upon a relational understanding of dementia, a psychosocial critique has yet to address a wider structural framework. To date, there has been little concern shown to trace connections between the experiences of people with dementia and a wider debate upon disablement. The possibility that dementia care may both benefit from, and inform, an understanding of the socially constructed and constituted barriers to social inclusion for disabled people, remains largely unexplored.

Becoming dementia:

Throughout this study, attention is paid to how the discursive construction of dementia serves to organise care settings. The dominant biomedical model of dementia is therefore interrogated according to how a way of seeing produces a way of knowing the person with dementia. A key feature of this being the extent to which identity is ordered in care and a prevailing discourse frames understanding.

"Just as a discourse 'rules in' certain ways of talking about a topic, defining an acceptable and intelligible way to talk, write, or conduct oneself, so also, by definition, it 'rules out', limits and restricts other ways of talking, of conducting ourselves in relation to the topic or constructing knowledge about it." (Hall, 2001, page 72)

'Ruled in':

At present, an individual diagnosed as 'with dementia' is rendered open to judgement and evaluation according to a medicalised disease narrative. A great deal of what a person says or does is vulnerable to interpretation as a symptom (Bond 1992). Authoritative constructions of dementia thereby provide a resource for interpretation. This pre-existing discourse informs attitudes, expectations, care and social engagement. Knowledge of the discourse substitutes for an understanding of the person. Thus, 'dementia' is imposed



through care. The discourses that have evolved to explain dementia represent knowable and concrete aspects of the social experience of the condition.

'Ruled out':

It is beyond the remit of medicine to account for social experience. Even though life in general unfolds in residential care settings a biomedical model of the disease is unable to encapsulate much of this experience. The medical gaze overlooks identities and social relations. For this reason, without a detailed working knowledge of a person's biography, 'dementia' emerges as an over-arching motif of identity - a global state. The potential to exercise or even to talk of alternative identifications is ruled out (Bender and Cheston 1997).

At the levels of research, policy and practice, dementia remains the key identifier for people living with the condition. The category of 'people with dementia' is rarely deconstructed. The diversity of the population to which this label refers remains unacknowledged and the possibility that such diversity may lead to important differences in experiences of living with dementia is largely unrecognised. It is therefore useful to consider those aspects of life in care that seem to have received little attention to date, and to question why this is.

The worth of attending to gender has a significant precedence. Across time, differing cultures and social institutions, gender has been shown to have a crucial influence upon social relations. As such, it is argued that gender is 'a fundamental relationship of social organisation' (Arber and Ginn 1995a, page 2). It is therefore remarkable that despite the vast resources that have been mobilised to explore the lives of people with dementia and the provision of care, rarely has gender been considered a potentially fruitful source of investigation. Perhaps this signals an assumption that gender has ceased to be a significant aspect of life for those residing in care. Or, that to care for a person with dementia does not require attention to the gendered features of this support. It may however indicate that



gender has a presence and influence that is currently neither well understood or fully acknowledged.

## 2. PERSPECTIVES

### Introduction:

Throughout this study an attempt will be made to place the analysis and subsequent discussion of data within a context of existing research and to review current debates of relevance to the emergent issues. Integral to this endeavour will be an on-going discussion of wider theoretical perspectives and their shaping influence upon the study. As such, this chapter will seek to outline certain underlying themes, with the intention that these will be further explored as the study unfolds. This opening discussion will seek to establish the framework of the study and to offer an account of the logic that has structured the project.

### Dementia, selfhood and social relations:

An understanding of dementia now has a life outside of medicalised definitions of the disease. The scope of research in the field has broadened to include a range of perspectives on the condition and approaches to the provision care. Of particular importance have been developments to an understanding of the social experience of dementia. According to psychosocial perspectives, a notion of selfhood is often invoked out of a concern to highlight the social impact and consequences of dementia (Sabat and Harre 1992, Herskovits 1995). To date, psychosocial constructions of dementia are characterised by reliance upon the notion of a pre-morbid selfhood as coherent and unified in order to dramatise the disrupting impact of the disease. Indeed, some notion of a unified self may be understood as discursively necessary in order to account for dementia's fragmenting effects. Crucially, the notion of a disrupted sense of self has underscored the significance of care. Supportive relationships have been argued to assist in the maintenance of selfhood for people with dementia.

Despite the centrality of selfhood to psychosocial accounts of dementia, a relationship to social identity has been less clearly delineated. Kitwood (1997) has drawn upon



constructionist theory to outline the concept of 'Personhood', a notion of subjectivity that specifically attends to an experience of dementia. Personhood is defined as:

“... a standing or status that is bestowed upon one human being, by another, in the context of relationship and social being. It implies recognition, respect and trust.”  
(Page 8, 1997)

Kitwood's conceptualisation of dementia represents a significant break from bio-medical constructions but overall, is notable for an inattention to social identity. While the notion of Personhood places emphasis upon the relational nature of self, it is strikingly apolitical, arguably de-politicised. Such a formulation appears to overlook the manner in which identity mediates relationships. As such, this study will endeavour to demonstrate that the social evaluation of identities structures the 'standing or status' that is bestowed upon a person and that power relations are always integral to this process. Such an approach raises the question of whether it is viable to conceive of Personhood without encompassing the interplay of a variety of social identifications, including gender.

The debate on dementia has yet to encompass an attention to identity. It will therefore be argued there exists a need to engender dementia and to consider the significance of gender and of gender's connections, to an understanding of the condition. A gendering of dementia inevitably challenges a rigid divide of disease from social experience. The facticity of medico-scientific constructions will therefore be questioned, opening the debate on dementia to issues of power and recognition of the socially constituted and constructed nature of the condition.

Identity:

Identity has emerged as a key feature of the debate on social relations and the organisation of power. Increasingly, it is argued that identity is usefully understood as composite and contingent upon context (Hall 2000). Identity alludes to a whole series of relational categories but also signifies their connection and interaction. Through an attention to these categories as sites or axes upon which power is organised, the inherently politicised nature



of identity has been underscored. However, a concern exists to distinguish identity as a discursive construct from that which it purportedly denotes.

"To what extent is 'identity' a normative ideal rather than a descriptive feature of experience?" ... "The 'coherence' and 'continuity' of 'the person' are not logical or analytic features of personhood, but, rather, socially instituted and maintained norms of intelligibility" (Butler, 1990, page 23).

The notion of identity is therefore a tool for organising knowledge. It operates discursively to shape the representation of social experience. In contrast to notions of a 'pre-social' subject, identity refers to a fluid and negotiated social experience. Thus, it has been argued that identity represents the means to re-articulate the relationship between subjects and discursive practices (Hall 2000).

#### Discourse:

An attention to discourse has been integral to the elaboration of a notion of identity. It has been argued that discourse refers to "the systems of meaningful practices that form the identities of subjects and objects" (Howarth and Stavrakakis, 2000, page 3). Social categories, routines, attitudes and identities are thereby viewed as constituted through discourse. An understanding of discourses as historical constructions signals the contingency of social identity.

However, discourse theory has developed as a broad field, traversing a variety of disciplines and as such, it may be argued there are multiple dimensions to discourse both in terms of how it is understood and applied. As systems of representation, discourses structure ways of knowing and provide the means of interpreting social experience. According to this approach to discourse, emphasis has been placed upon the ordering or hierarchy of such systems of representation, stressing the need for attention to how certain discourses appear dominant and take on an authority that is linked to certain groups and perspectives (Wetherell 2001). As an example, Potter (1996) has generated a critique of scientific discourse, highlighting the manner in which the facticity of scientific knowledge



is discursively achieved and through which a notion of objective truth is upheld. The hierarchy of discourses in any given setting constructs and perpetuates relations of power, not only through an authorisation of particular perspectives but also according to the privileged or preferential access that certain groups and individuals have to an authoritative discourse.

"Some 'voices' are thereby censored, some opinions are not heard, some perspectives ignored: the discourse itself becomes a 'segregated' structure." (Van Dijk, 2001, page 304)

Recognition of the discursive constitution of identity has prompted a cross-disciplinary 'linguistic turn' (Cameron 1998) leading to growing interest in the analysis of social interaction and communication. It has been argued that discourse represents a challenge to a dualism of structure and agency whereby social processes and particularly processes of meaning-making have traditionally seemed to have little relevance to social order (Coupland and Gwyn 2003). Discourse theory has underpinned the development of a critique of existing research into gender and communication. In particular, an understanding of gender based largely upon comparative studies that highlight differences between men and women has come under question. This body of literature has been challenged on the grounds that it is suggestive of fixed attributes and static categories of identity.

"Social practices that construct women and men as distinct categories by converting an average difference into a categorical difference' ... 'negate the major pattern of difference that occurs within sexes rather than between them" (Connell, 1987, page 80).

Bucholtz (1999) has argued that sociolinguistic analysis has conventionally taken language to be central and placed an emphasis upon generating norms that overlook within-group variation. As such, Eckert and McConnell-Ginet (1992) stress the need to combine an attention to language and practice in the context of particular settings. Such a perspective challenges a tendency within sociolinguistics to assume that gender can be isolated from other aspects of social identity and relations, and that gender has the same



meaning across differing communities. Eckert and McConnell-Ginet therefore propose that attention is paid to 'communities of practice' in order to avoid constructions of men and women as internally homogenous groups and to facilitate an understanding of the situated construction of gendered identities.

Discourse theory has therefore generated alternative approaches to language in context and a re-conceptualisation of the underpinning notions of gender that inform investigations of communication and social relations. Specifically, there has been a movement towards an understanding of identity as contingent and of gender as socially produced and achieved, rather than as a fixed property that pre-exists social engagement.

Dimensions of gender:

At the heart of this study lies a concern to explore gender. However, a simple definition of what gender means is difficult to find, perhaps signalling that there is no neutral way to characterise it. Having drawn upon a broad array of existing studies deemed relevant to the present investigation it seems pertinent to note how uncommon it has been to encounter clear definitions of gender on offer within them. This would seem to indicate an assumption that consensus exists as to what is meant by this term. However, as the ensuing chapters will attest, emerging from this body of literature is a diverse range of perspectives upon what gender refers to and how it is understood to operate. Such variation may indicate that gender has a meaning that is specific to particular standpoints or disciplines. Certainly, there appear to be traditions inherent within particular types of social research that uphold certain constructions of gender. However, an alternative reading is that gender is multi-dimensional, that there are layers to this aspect of identity and social relations that invite interrogation from more than one angle.

The present study adheres to this latter reading. Throughout, an attempt will be made to explore the differing dimensions of gender and to trace their connection in relation to dementia care and its wider context. However, such an endeavour does not negate the requirement to give an account of the standpoint taken by the study, not least because,



how gender is perceived serves both to facilitate and constrain its exploration.

Conventionally, gender has been treated as a dichotomous category, used to denote differences between men and women. Yet, such an understanding proves problematic when seeking to explore gender as an ideology, upheld socially in particular forms that support certain perspectives and interests. As such, it seems useful to conceive of gender as a 'normative framework' (Butler 1993). Furthermore, when understood as the sum of various differences between women and men there seems little room to consider gender as a process.

For the present study various dimensions of gender will be explored, and in so doing an attempt will be made to demonstrate that these dimensions interconnect, rather than existing in an 'either/or' relationship to one another, as often seems implied within particular traditions of social investigation. The study is therefore organised to take account of these dimensions.

"Gender denotes a hierarchical division between women and men embedded in both social institutions and social practices. Gender is thus a social structural phenomenon but is also produced, negotiated and sustained at the level of everyday interaction." (Jackson and Scott, 2002, page 2)

It will be argued that to explore gender requires an attention to relations of power. For this reason, there is a need to locate gender within social hierarchies. Such hierarchies structure divisions between men and women but also underpin differentiation between women and between men.

However, while gendered divisions can be traced across time and differing domains, gender should not be considered immutable. What gender means and how it is experienced is always situated. It cannot be taken as fixed when viewed as contingent, located in time and place. For this reason, gender will be taken to refer to a form of social practice, and thereby continually under a process of negotiation and reconfiguration. Such a perspective requires an understanding of gender as a relational category, hence the concern of this study to examine gender relations. In this respect discourse is a useful



vehicle by which to consider gender dynamically, both at an interpersonal and wider social level. Gender functions discursively as a notion that organises understanding and in so doing, it mediates the ways in which women and men are represented. Through an attention to discourse it is possible to consider the processes by which differences are translated into (dis)advantage, and to think critically about an array of social practices and relationships that indicate the gendered organisation of social relations.

The study has therefore been organised according to a desire to encompass both structure and fluidity (hierarchies and interactions). However, attention will be given to the interplay of these dimensions in order to underscore the manner in which everyday social interaction is shaped by wider frameworks but also serves to uphold them.

Hierarchies:

The take-up of Gramsci's concept of hegemony has proved an important influence upon an understanding of how power is exercised, with hegemony now recognised as a key mechanism by which social hierarchies are upheld. Gramsci has highlighted the non-coercive dimension of power, proposing that a naturalisation and wider social acceptance of the perspective and interests of the ruling class serve to maintain power relations. Within the debate on identity, the notion of hegemony has been appropriated and put to use beyond its class-based origins. The relation of differing standpoints to a hegemonic perspective has been explored through various categories of identity, including 'race' (Hall 2002) gender (Connell 1987) and sexuality (Butler 1990). Hegemony has thereby come to signal an ordering of identities according to relations of power.

Connell's (1987, 1995) notion of 'hegemonic masculinity' provides a pertinent example of how such hierarchies of identity are realised. In the development of a materialist account of gender, Connell has challenged constructions of identity as an array of repeated practices, arguing that such discourse-based approaches fail to account for conditions of material, social and economic inequality. It is argued that both benefits and constraints are associated with differing types of masculinity and the process by which other perspectives



are subordinated signals the imbrication of gender, 'race', class and sexuality. According to Connell, institutions serve as collective sites of gender configuration, they are 'gender regimes' (page 119, 1987) that influence emerging masculinities through authorisation of particular positions and thereby create local hierarchies of identity. The suggestion that identities are ordered within particular domains or settings challenges constructions of patriarchy as monolithic.

A central concern for Connell, in the formulation of a hierarchy of masculinities is the process by which individuals take up certain gendered positions with an associated status and leverage. Connell's gradation of masculinity is useful in that it highlights the intersection of gender with other social divisions according to localised configurations. However, in an attempt to label a diverse range of masculinities, according to their context, a notion of power is developed as invested in particular categories of masculinity. Such a model seems less well equipped to encapsulate the fluidity of identity and the manner in which power is achieved through participation in a variety of practices organised according to gender.

#### Interactions:

Across this study the heading 'interactions' refers to a number of interconnected concerns. It signals an interest in the interactive and communicative experiences of those who live and work in dementia care settings. The theme of interactions also indicates a concern to explore the discursive constitution of social identities and power as embedded within social relations.

Foucault (1977, 1985) has proposed that power is both constituted and exercised discursively and as such is fragmented, multiply located and historically changeable. It is argued that power circulates and has a capillary social presence and is therefore neither linear nor uni-directional. Discourses construct subject positions in the perpetuation of relations of power. Authoritative discourses are argued to produce subjectivity through self-regulation and discipline.



Foucault's construction of the subject as relational and contingent has informed the development of an understanding of identity as fluid. Butler's notion of performativity provides an example of an approach to identity as socially practised and achieved thereby eschewing fixed and stable notions of subjectivity. It is proposed that gender is both constituted by and articulated through a 'sustained set of acts, posited through the gendered stylization of the body' (page XV, 1999).

Gender 'connects':

The heading 'interactions' also denotes a concern to examine the ways in which gender imbues other aspects of social experience and identity and, in turn, is shaped by them. Such an approach derives from a desire to question how gender operates discursively to organise social investigation and understanding. It will be argued that when treated as a distinct and separate category, the ways in which differing gendered standpoints are produced by such interactions are likely to be underplayed. A pertinent example of such an interaction is the relationship of gender to sexuality.

Scott and Jackson have argued, "sexuality cannot be understood without consistently paying attention to its intersection with gender" (page 169, 2000). Gender is implicated in the production of a hierarchy of sexualities, while sexuality shapes gendered identities (Richardson 1996). Thus, Butler (1990) stresses the need to connect gender and sexuality as an avenue to understanding how certain privileged standpoints are upheld by an interaction of the two. A gender hierarchy is argued to create conditions of compulsory heterosexuality, with gender norms policed in order to uphold heterosexual hegemony. This interplay underpins the naturalisation of heterosexuality and its continued status as an unexamined norm. Indeed, even within such critiques of this hegemony rarely is heterosexuality treated as anything other than an unexplained and monolithic norm (Jackson 1996).



An important component of Butler's argument has therefore been a questioning of the manner in which gender has been addressed as abstracted from a wider context of identifications. It is argued that a reified category of gender has been:

"... fully decontextualised and separated off analytically and politically from the constitution of class, race, ethnicity, and other axes of power relations that both constitute 'identity' and make the singular notion of identity a misnomer." (Page 7 1990)

Bel hooks (1981) has drawn attention to the outcome of this decontextualisation, challenging the imperialism of the category of 'woman' in white, middle class feminism. Hooks argues that gender, ethnicity and class interact, leading to radically differing experiences and conditions. A generalised category of gender imposes a problematic unity upon the representation of social experience, at once over-simplifying and exclusive in effect. Thus, a diverse range of identifications are conflated when abstracted universal categories are relied upon rather than interrogated.

Similarly, Nasir (1996) notes 'the general tendency in critiques to separate issues in order to study them' (page 16 1996). Consequently, concepts of social identity are fragmented, and unitary single-factor categories upheld within discussions of social divisions. Nasir suggests that under such conditions, interactions of 'race' and gender are named rather than theorised, with 'race' often treated as an add-on to explorations of gender inequalities, according to the logic of double jeopardy. It is argued that gender serves to organise the discussion of social relations, imposing an (artificial) order upon an understanding of identity and social experience.

However, attention to the heterogeneity of differing masculinities and femininities does not detract from recognition of the hierarchical divisions between men and women. Value-laden representations of gendered difference have proved crucial in the maintenance of power. A prominent feature of feminist theory has been a challenge to a naturalised and largely unexplored or explained masculine perspective that underpins the evaluation of femininity, according to which women are represented as 'other' and subordinate. One



process through which such devaluation occurs is the structuring of gender categories as binary oppositions, set within a context of polarities imbued with gendered connotations: culture/nature, active/passive, reason/emotion.

Private/public:

A key binary divide, of particular relevance to the present study, is that of the public from the private. A gendering of this division has served to consolidate gender inequality. The ideology of a public/private divide, premised upon an association of femininity with the private and personal, and the subsequent devaluing and exclusion of this sphere from the discursive construction of citizenship is an integral component of the hierarchy of social membership. Such exclusion relies upon an implicit construction of the private as 'pre-social' and thereby fails to encompass the forms of oppression that exist within this domain (McLaughlin 2003).

Lister (2003) has argued for the need to re-appropriate such key strategic concepts as citizenship and to 're-gender' the relationship of the individual to society and an understanding of the basis of social membership. It is argued that an exclusion of the private sphere from the development of a state infrastructure has marginalised women, attenuating their claim to full citizenship and the attendant rights associated with this status. Of particular consequence has been the veiling of care as a crucial factor in women's relationship to citizenship. Lister argues that a division of the public from the private has denied the significance of care in enabling social participation and has obscured the manner in which men have traditionally failed to fulfil their private obligations as citizens. Thus, citizenship represents not a divide, but a hierarchy, built upon processes of inclusion and exclusion, that support a hegemonic perspective.

"The universalist cloak of the abstract, disembodied individual has been cast aside to reveal a definitely male citizen and a white, heterosexual, non-disabled one at that." (Page 68, 2003)



With regard to discourses of need, Fraser (1989) has also highlighted the function of a gendered divide of the public from the private. Fraser has argued that the discursive construction of need has been largely overlooked, hence little attention has been given to the fairness and adequacy of how need has been defined and represented. A key feature of this discursive arrangement is that needs have been allocated to domestic or economic contexts, thereby underpinning the ways in which they are interpreted and articulated. This system of organisation has served to "enclave certain matters into specialised discursive arenas" (page 162, 1989).

### Body politics:

An attention to the politics of embodiment has been a crucial feature of a critique of social policy and the wider issue of social membership. Rowbotham (1976) has traced the impact of embodiment upon women's social participation through time. Charting the history of women's struggle for reproductive rights, Rowbotham has demonstrated the manner in which the body has proved a key site of women's regulation and subordination. Thus, an exclusion of the private from historical narratives has led to a concealment of women's lives and the impact of an embodied social experience upon their rights and social inclusion.

Rioux (2002) has argued that disability also has a crucial bearing upon social rights and membership. Constructions of citizenship are argued to be contingent upon particular bodily and cognitive capacities and as such 'universal' rights are founded upon an implicit mental and physical norm.

"The disabled status has almost universally been a condition that has been used as a rationale for disempowering people from citizenship." (Page 217, 2002)

The disability movement has challenged the exclusion of the body from constructions of subjectivity and citizenship. Corker and Shakespeare (2002) have argued, "subordinate groups are defined by their bodies and according to norms that diminish and degrade them" (page 12 2002). Thus, bodily devaluation underpins social exclusion and



disadvantage. Through an attention to the 'othering' of bodily difference, a social model of disability has been developed. Awareness has been raised of the structural effects of disablement as a form of social oppression, with disability redefined as "the outcome of social arrangements and practices which work to exclude and disadvantage people with impairments" (Thomas, 1999, page 1).

A social model of disability represents a challenge to a (medicalised) focus upon impairment as the source of restriction to social participation. However, a subsequent critique of the social model of disability has challenged this focus upon socio-structural barriers for ignoring the cultural and experiential dimensions of disablism (Thomas 1999). It has also been argued that such a concept overlooks the interaction of disability with other forms of social oppression, and not least that 'disability is fundamentally gendered' (Thomas and Corker, 2002, page 19).

The politics of space and time:

"We all write and speak from a particular place and time, from a history and a culture which is specific. What we say is always '*in context*' - positioned" (Hall, 1990, page 222, original emphasis).

Increasingly it is argued that space and time are usefully understood both as constitutive and expressive of social relations, thereby offering a useful site through which to conceptualise social experience and subjectivity (Soja 1997). Time and space hold a social worth that make them part of the negotiation of power; they are contested and open to negotiation and exchange. The commodification of time and space may be understood as a facet of social power, their appropriation representing a form of power-claiming (Harvey, 1989).

Identity in place:

How space is organised and the meanings that are ascribed to it represent a social product (Keith and Pile 1993). From a variety of perspectives it has been argued that the



organisation and arrangement of space have an uneven social impact. For example, the gendered division of time and labour is tied to place, while identity is expressed and maintained through place according to these gendered associations (Women and Geography Group 1984). Oliver (1990, 1996) has argued that the physical and built environment has the potential to both enable and disable, thereby mediating social participation. While 'race', ethnicity and nationality are also key determinants upon a potential for mobility and movement (Richmond 1994).

Age represents another key aspect of identity that may be understood to mediate an individual's relationship with space and place. In a study of constructions of ageing, Laws (1997) has drawn attention to the particular images of ageing associated with residential care, arguing that such representations signify the ideological work that is expressed through landscapes of old age. Experiences of ageing differ according to the contexts and settings in which people are located while perceptions of a place change as people age (Harper and Laws 1995). It is important therefore to consider how social hierarchies are realised through placing people in space (Ardener 1993).

#### Identity in time:

Two key aspects of the social investigation of time consist of the way identity has been understood to mediate experiences of time, and the way in which identity is reconfigured through time. Gender has emerged as a crucial variable in both debates. Davies (1990) has highlighted the dissonance between (masculine) clock time and women's experience of time, not least as tied to their caring experiences. Thus, temporal patterns are argued to differ for men and women, a key division being a continuous experience of time for women compared to a discontinuous experience of time for men, who are thereby better able to take 'time out'. In accounting for this division, Davies argues it is crucial to consider women's time in relationship to others, thus decisions made with regard to a balance of paid and unpaid work are often premised upon caring commitments.



Within social gerontology attention has been given to the various social outcomes of ageing and the manner in which ageing reconfigures social relations and identities. However, McMullin (1995) has argued that, in both theory and research practice, gender is frequently 'added on' as a variable in comparative studies of the life experiences of older men and women. Such an approach is deemed problematic according to an argument that age and gender interact differently for men and women. Arber and Ginn (1995a) and McMullin (1995) have therefore proposed the need to elaborate a sociological understanding of how individuals age in gendered ways.

### Mobility:

In light of the ways that globalisation has mobilised people, objects and networks of communication and association, Urry (2000) has argued for the need to reconstruct notions of the 'social as society' into the 'social as mobility' (page 2, 2000). Urry notes that mobility takes multiple forms, as both a geographical and social phenomenon. As such there is a need to theorise experiences of mobility and to employ an array of metaphors of movement, flow and flux to denote the acceleration and expansion of mobility as a key feature of contemporary social experience.

"These mobilities criss-cross societal borders in strikingly new temporal-spatial patterns (and) hold out the possibility of a major new agenda for sociology." (Page 2, 2000)

A key feature of this re-thinking of social theory is the need to attend to how identities mediate and intersect with experiences of mobility, leading to fluid relationships with place and space.

With regard to an understanding of mobility as a fluid experience of class status particular attention has been given to paid employment, labour markets and occupational change. However, despite the gendered patterning of employment little consideration has been given to gendered differences in social mobility. Payne and Abbott (1990) have challenged conventional notions of social mobility as focussing primarily upon class,



arguing that employment opportunities and career paths are gender specific and for this reason there is a need to consider the interaction of class and gender. It is argued that in contrast to men, women are less likely to have 'linear' careers, their relationship with the employment market often taking on a differing form due to familial care-taking responsibilities.

"Downward mobility is the most widely shared experience of women's lives. This is not true of men" (page 163, 1990).

Given the influence of gender upon social mobility, Payne and Abbott argue there is a need to look beyond mobility as a move from one origin to one destination and to consider mobility profiles. Thus, women's experiences of both upward and downward mobility, shaped by unpaid labour and reproduction require attention to their relationship with the employment market (and associated class status) as it alters over time.

A similar inattention to gender characterises an understanding of migration as a geographical form of mobility. Despite evidence suggesting that migration is patterned by gender (Phizaklea 1983, Sharpe 2001), mainstream accounts of migration have largely overlooked the specific issues faced by migrant women, the differing outcomes of migration for women, and gendered differences in the experience of migration (Sharpe 2001). Litt and Zimmerman (2003) have placed emphasis upon the crucial role that care plays in structuring experiences of migration and mobility. It is argued that globalisation has had a shaping influence upon emerging forms of citizenship and economic displacement that are founded upon gendered divisions and differences.

"Migration and global economic interdependence build on and reproduce gendered inequalities embedded in structures of care work, in both paid and unpaid forms."  
(Page 163, 2003)

In arguing for the need to address gendered experiences of migration, McDowell (1999) has suggested that migration interacts with identity and social experience. As such, there is a need to consider experiences of migration in terms of mobility and thereby to look beyond a focus upon origin and destination.



"While the causes of migration and the impacts on the receiving and donating communities have been relatively well documented, until recently far less attention has been paid to the journey itself" (page 203, 1999).

It therefore seems there is a need to engender mobility and to consider how gendered differences serve to disrupt conventional frameworks for analysing and understanding its various forms. Coupled with this, there appears to be an overall inattention to identity as fluid and changing. This stems from a tendency to consider movement in terms of a starting and end point rather than as a process with distinct qualities and properties that hold significance for the configuration of identities and social relations.

Narrative:

"One way to avoid the hazards of rigidifying aspects of identity into a misleading categorical identity is to incorporate into the core conception of identity the categorically destabilising dimensions of time and space." (Somers, 1994, page 606)

Somers (1994) has argued that an attention to narrative facilitates an understanding of identity as under a continual process of construction and re-evaluation. Thus, identity is constituted through narrativity, and an examination of narratives allows for an understanding of identity as embedded in networks of relations that shift over time and space. Narratives provide a framework by which sense is made of an unfolding social experience, and an array of existing repertoires are drawn upon to create an order and logic to biography and a basis upon which to act. As such, Somers argues that narrative should not be considered merely a means of representation but instead, be viewed ontologically, as the conditions of social experience.

Similarly, Coupland and Nussbaum (1993) have suggested that narratives represent the process by which individuals respond to continually evolving circumstances and align themselves in relation to them. From this perspective selfhood is considered a 'project', always under construction. Narrative is therefore the means by which individuals give



meaning to experience, through time, signalling the storied quality of social life. Gergen and Gergen (1993) argue that gender functions to set parameters to the forms of narrative that are open to women and men.

"To the extent that narratives are gendered, furnishing different structures of meaning for men as opposed to women, so do they contribute to cultural patterns that differentiate between the genders and prescribe what is both likely and unlikely during a lifetime." (Page 30 1993)

While narrative offers a useful means by which to account for a fluid experience of social identity, to date, there has been little consideration given to how such a formulation may inform an understanding of dementia. Indeed, it seems that a capacity to produce narratives and to act upon them, as a core feature of social experience, is challenged by an experience of dementia. A notion of narrative is premised upon an assumption that an individual holds a capacity to locate experiences in a wider biographical context and make sense of such experience in light of this wider context, with memory a key tool in so doing. It remains open to question how the erosion of such a capacity might disrupt this process or what it means for an understanding of social experience when the production of narratives is problematised.

## CONCLUSION:

In this chapter an attempt has been made to outline a series of debates in social theory and investigation that are relevant to the present study. In particular, attention has been given to how these debates have addressed gender and generated constructions of gender that provide ways of understanding this multi-dimensional aspect of identity and social relations. However, in drawing a conclusion from across this diverse but often overlapping range of perspectives it is pertinent to note how infrequently they have encompassed an experience of dementia. And, how rare it is to find such debates referenced within research into dementia.



As such, it seems useful to echo Fraser's (1989) argument with regard to discourses of need - that it is important to question why certain social issues and phenomena have become enclaved within specialised discursive arenas. This process of allocation seems to have had a crucial bearing upon the terms and frameworks that are available to the discussion, interpretation and representation of dementia. Of particular pertinence to the present study is the question of why a broad and increasingly prominent debate upon identity has yet to surface within dementia studies. It therefore seems relevant to consider what forces are at play that have 'ruled out' issues of identity, and the relations of power that adhere to this notion, from the field of dementia research.

It may also be argued that dementia presents a challenge to a great deal of what has been taken as given within many of these wider debates. It seems that a condition characterised by progressive cognitive and communicative impairment raises questions regarding an understanding of identity as constituted in and through language. There has been little consideration given to what it means to an understanding of gendered identities if a capacity to reiterate a sense of self, at the level of everyday communication, is compromised.

The experiences of people with dementia have yet to be recognised in the development of a social model of disability. This raises the question of why it is that disablement has not been deemed relevant to an understanding of the experiences of those with cognitive and communicative forms of impairment. And, of what challenge dementia might represent to a social model of disability, given that it has relied so little in its formulation upon the input and experiences of people with dementia.

Perhaps most significantly, it seems important to question what outcomes there have been for people with dementia as a result of the partitioning of dementia within a medicalised discursive arena. At present it seems a debate upon citizenship and rights sits uneasily with discourses on care that emphasise protection and the minimisation of risk. There has been scant consideration given to the ways in which a debate upon social inclusion and membership might be meaningful to people who reside in institutional care. And, it is

open to question what mechanisms currently exist to safeguard the rights of people with dementia, following admission to care.

It therefore seems both relevant and applicable that an attempt is made to introduce dementia to these wider debates and in so doing to consider what dementia studies have to offer with regard to a critical evaluation of these existing perspectives.



### **3. SCOPE AND METHODS**

#### **Introduction:**

This study has been undertaken within the context of a wider investigation of communication and dementia care: Alzheimer's type dementia: Communication Patterns and their Consequences for Effective Care (CPCEC) (Vass et al 1998). The research was carried out exclusively within care facilities owned and run by Jewish Care, a voluntary sector organisation offering care and support to the Jewish community. As such the service users participating in the study were drawn exclusively from the Jewish community. All participant workers were employed by Jewish Care. However, the relevance of this project to a wider population is clear.

With an increasing prevalence associated with ageing, the incidence of dementia crosses social and demographic boundaries, with comparable symptoms experienced irrespective of culture, class and ethnicity. The findings of this study are therefore of use and relevance to an understanding of other situations and settings. The social and cultural identity of participant service users has offered an opportunity to consider issues relating to the impact of dementia upon both women and men of a minority community and the provision of care cross-culturally, which has relevance to many, if not most, dementia care settings.

#### **Aims**

The study has been undertaken and guided according to two main concerns:

- 1.) Gender in care: Firstly, given the paucity of existing research in this field, an intended outcome of this investigation has been to draw upon the wider study and conceptualisation of gender to offer insights that may enhance the existing provision of care to people with dementia.

- 2.) Care in gender: Alongside this objective, the dementia care setting offers a particular social context, with identifying discourses and practices, from which to develop a critique of existing debates centred upon gender and gender relations.

The research context and considerations:

Despite a broad and increasingly comprehensive debate upon gender and care the specific constellation of social relations associated with residential dementia care has rarely come within the orbit of this discussion. The lack of existing research therefore provided a motivation for undertaking the study while shaping the manner in which it unfolded. Without an existing body of evidence with which to correspond it was deemed appropriate to take an exploratory approach to the field. The study is shaped by a concern to identify the variety of ways in which gender issues may be understood as relevant to and manifest within residential dementia care.

### Analysis

The breadth of the study stems from the diverse ways in which gender may be argued to inhabit and influence social relations. The multiple forms of data generated by the CPCEC project and upon which this study draws thereby usefully facilitated a 'mapping' of gender relations in care. Throughout the study, it is argued that gender may usefully be understood as multi-dimensional or layered, for this reason the analysis and discussion of data draws upon a range of analytic practices. It is therefore useful to highlight what may be considered a common thread to this variety of approaches.

Discourse analysis:

Existing reviews of discourse analysis have highlighted the variety of disciplines within which such analysis takes place and the range of differing formulations of discourse that inform these undertakings (Jaworski and Coupland 1999, Wetherell et al 2001). An attention to language is a common and shared aspect of the differing traditions of



discourse analysis, however many analyses extend beyond a consideration of language to include wider processes of interaction and practices by which meaning is constructed.

This range of concerns highlights variance in how discourse is defined with consequent implications for the scope of research, i.e. what aspects of a situation or setting are considered to be of relevance to an investigation and why. Scope thereby holds implications for the breadth and volume of data incorporated. For example, the close attention to both verbal and non-verbal aspects of speech characteristic of such disciplines as conversation analysis, commonly leads to just a few turns at talk or utterances being taken as a unit of analysis. Such an approach is driven by a concern to explore everyday language use as a site for social action. By contrast, a view of discourse as productive and constitutive of meaning and subjectivity suggests a far wider compass according to Foucauldian perspectives. The focus of analysis thereby traversing an entire 'discursive formation' at a given point in time, centred upon particular situations, settings or subject positions.

"Discourse in this usage is not purely a 'linguistic' concept. It is about language and practice. It attempts to overcome the traditional distinction between what one *says* (language) and what one *does* (practice)" (Hall, 2001, page 72, original emphasis).

Despite the range of practices employed to investigate discourse and variance in the level and potential volume of data associated with differences of scope, certain key issues unite or at least associate this range of undertakings, understood collectively as discourse analysis. Common ground for the many forms of discourse analysis is a particular perspective on epistemology. As a tradition that is rooted within a constructionist paradigm, discourse analysis problematises the notion of objective truth and in so doing focuses upon the production of meaning and the manner in which this takes place according to relations of power.

Wetherell (2001) suggests that discourse analysis pursues a tripartite approach to investigation, attending to the content of discourse, the representational work that it does and the 'interpretative resources' upon which individuals and groups draw in order to offer



their accounts or version of events. For the present study, seeking to explore gender relations in a dementia care setting, attention is therefore paid to each of these aspects of discourse. In so doing, the scope of the investigation shifts from a wide vista across the organisation of social relations associated with care to a close attention to particular episodes of interaction. The shift in focus dictates the employment of a number of analytical approaches to data that may be considered to fall within the tradition of discourse analysis. What unites this variety of practices is a concern to explore gender as discursively constituted and thereby to show how localised events and encounters both reflect and uphold wider social processes.

Discourse analysis is concerned with interaction as the site within which meanings are socially produced and thereby focuses upon representation and the manner in which representation is organised and achieved. The processes by which meaning is produced are deemed to warrant critical attention, with an attention to power relations an integral feature of this endeavour. Thus, Wetherell (2001) argues that key concerns for discourse analysts include:

"How people, groups and institutions mobilize meanings. How some interpretations become dominant and whose interests are served. It has been recognized that control over discourse is a vital source of power and also there are limits to this control because meanings are fluid and escape their users and can be mobilized and re-worked to resist domination." (Page 25, 2001)

A key feature of discourse theory is the development of an elaborated and revised notion of power. This relates both to an understanding of the location and operation of power and a concern to demonstrate the difficulties in assuming a certain flow of power or the fixed nature of power imbalances. Rather, as Foucault (1977) suggests, power circulates within social relations and is therefore capillary in nature. Another central concern for discourse theory is the questioning of a coherent or unified subject or standpoint. As previously discussed, discourse theory takes identity to be fluid and fragmented. Furthermore, identity is understood as contingent, situated in time and place. This concern with situation also raises issues with regard to the position of the researcher and the status of the knowledge that is generated from research. Thus, a guiding concern for the present study



is to view the undertaking of research and the knowledge that stems from it as situated, necessarily partial and bounded. And, thereby to eschew what Haraway (1991) describes as the 'god-trick' of "being nowhere while claiming to see comprehensively" (page 191, 1991).

The study context:

As this study has been conducted within the context of a wider investigation of communication, areas that could have come within the scope of the wider project were allocated to the PhD leading, inevitably, to a degree of sharing between the two ventures. The study has benefited considerably from the levels of access, host organisation co-operation and sophistication of data-gathering tools and equipment, normally outside the reach of a PhD study.

An early step in the development of the study of gender relations was an agreement with the wider research team that issues concerning gender and gender relations would be the domain of this study and thereby not under analysis by the wider investigation of communication patterns. Where relevant, findings from the wider project have been incorporated within this parallel study and vice versa. Throughout the study, attention has been given to the policing of the boundaries of the two investigations and wherever applicable the CPCEC project has been referenced in order to indicate what may rightly be considered the domain of the wider project.

This wider context also holds a further and influential significance for the present study. The methods used for the CPCEC study led to the generation of particular types of data that shaped what may be said of the dementia care setting and how it may be represented. Thus, the generation of data, centred upon an attention to communication, has had a formative influence upon the evolving study of gender relations and the particular research questions to which it is oriented. In parallel to the CPCEC study's concern to explore the co-constructed and transactional nature of social encounters, the present study places emphasis upon gender as fluid and socially negotiated. This has involved an attention to



the influence of gender upon the organisation of social relations in care and how this is achieved and upheld, whilst exploring the variety of ways in which gender inhabits interpersonal relations and the patterns of day-to-day social interaction.

## Ethics

A number of key issues both structure and mediate a concern for ethics when undertaking social research. There is a requirement for research to be ethically accountable and, as such, to be prescient with regard to the potential consequences of employing particular methods and the possible implications findings may hold. Alongside such considerations, a key concern for the CPCEC project was the potentially vulnerable situation of many participants and the imbalances of power that characterised the social relations within the field of investigation.

As will be explored throughout this study, for many people with dementia a common aspect of the onset and progression of dementia is an experience of disempowerment. This occurs at a variety of levels and in a number of ways. In addition to the material and economic losses associated with many forms of disability, it may be argued that social status and leverage are compromised for people with dementia as a group. Also, at a more local level, disempowerment structures the network of interpersonal relations within which an individual is situated (Hanson, 1994a). Research in dementia inevitably enters into these relations of power and becomes a part of them. For this reason, there is a requirement to attend to ethical concerns in an on-going fashion and to bring into operation an ethical standpoint. This is necessary not only in anticipation of the many unexpected and unforeseen issues and dilemmas that the undertaking of research generates but also in the need to respond consistently to these dilemmas according to a clear ethical framework. Ethical accountability is therefore key to this field of research and it is essential that the undertaking of research is accountable to all groups and individuals involved.



For the CPCEC study a number of differing groups of stakeholders either directly or indirectly came within the scope of the study. These groups included people with dementia, Jewish Care staff, families of the participating service users and Jewish Care as an organisational body. Whilst consent to participate in the study was given by a selection of residents and workers, all those living and working within the homes incorporated in the study were potentially affected by the undertaking of the research. As such, posters announcing the filming and presence of the research team were displayed in each home and staff were invited to meetings at the outset of each course of filming to discuss the project. Throughout the period of fieldwork the researchers made themselves available to residents, staff and relatives to answer queries and to address any concerns raised.

A crucial stage of the CPCEC project was the development of a detailed 'ethics protocol' following prolonged discussions between the research team and the host organisation. As an outcome of this procedure, a paper has been published giving a full account of the protocol developed and used by the research team and the various outcomes and benefits associated with its use (Vass et al 2003). This study has therefore been governed and guided throughout by the ethical stance set out by the protocol and, alongside the CPCEC project, has been ratified by a Joint Ethics Committee from Middlesex University and Jewish Care.

## Methods

It is important to be clear that the methods, sampling and time frame of the CPCEC project (Vass et al 1998) were formulated and agreed prior to the commencement of the present study and will be fully accounted for in the write up of the wider project. The study of gender relations has largely made use of data generated for Phase 1 of the CPCEC project - residential care. The main sources of data drawn upon for the present study include:

- Interviews with 32 care workers of varying grades and six non-care workers.



- Video data generated from filming seventeen residents in eight units of five Jewish Care homes.
- Care home documentation held on each of the seventeen residents
- Diary entries and observations recorded throughout the period of fieldwork
- Interviews with 18 relatives/next of kin of the seventeen residents

In light of the fact that the methods for the present study were 'pre-set' and adopted from a wider project this chapter will pay particular attention to the interaction of the methods with the analytic approach taken by the study. Thereby to better account for the particular relevance that each method held for the present study.

Care Home Staff:

### Sampling

Jewish Care provided the research team with a breakdown, according to ethnicity and gender, of the 594 staff who were employed in both care and non-care capacities within eleven residential and nursing care homes. The breakdown revealed a gender mix of 93 men (16%) and 501 women (84%). The project utilised random selection in order to ensure that each participant in the project had an equal chance of selection and to minimise bias at the sampling stage. However, participants were selected in two groups, according to gender, in order to replicate the gender balance within the wider bodies of staff and residents.

From this original list a total of 123 staff were randomly selected with a gender mix of 28 men (23%) and 95 women (77%). This shortlist of staff included residential care assistants, night care workers, group leaders, qualified nurses, home managers and assistant managers and various non-care workers such as domestic staff, administrative staff, maintenance workers, laundry assistants and dining room co-ordinators. In all, the shortlist contained 34 (28%) non-care workers and 89 (72%) care workers of various



grades. A consent-gathering procedure, lasting for approximately three months was then pursued to recruit this short-listed group to the project.

#### Consent Gathering:

The first step in raising awareness of the project within Jewish Care was the distribution to all staff members of an introductory leaflet detailing the aims and objectives of the project. This was attached to the pay slips of everyone employed by Jewish Care. Following this, all short-listed staff were written to directly, inviting them to attend a meeting at Jewish Care headquarters, during which the research team introduced the project and staff were offered the opportunity to raise questions and concerns about their participation in the project. At the end of this meeting (which attracted 15 staff members), all those interested in participating were requested to complete a consent form, keeping a copy of this form for their own records.

Following this meeting, the remaining short-listed staff members who were unable to attend were contacted by the research team, either by telephone, in writing or in face-to-face meetings and asked to consider participating. All staff were provided with an information letter on the project, and consent form to complete and return with a second copy for their own records. Additionally, all staff were offered the opportunity of direct contact with the research team if they had any queries prior to signing the consent form. Staff were assured that their participation in the project would in no way effect their employment with Jewish Care and that all data generated by the project would be dealt with according to a strict code of confidentiality. Also that, despite signing the consent form, participants remained free to withdraw from the project at a later date if they so wished.

Following reservations raised by one of the home managers regarding the project, the research team attended the home, giving a presentation and answering queries from staff. Despite this, the home manager remained reluctant for this home to be included within the project and it was agreed that the home would therefore be excluded. Concerns voiced at



the presentation included issues of intrusiveness in using filming equipment and the fact that many staff and residents who had not agreed to participate in the project would be caught on camera. Some concerns had been raised with the home manager, by relatives of residents, prior to the meeting held at the home.

The outcome of the consent gathering process was that 32 care staff and six non-care staff agreed to participate in the project. This represented a response rate of 36% for care staff and 18% for non-care staff. All participants were interviewed using a semi-structured interview schedule, with an abridged version of the schedule used for non-care staff.

#### Residents and their next-of-kin:

Twenty-eight nursing and residential care residents of Jewish Care facilities were randomly selected from a pool of 78 (82%) women and 17 (18%) men, all of whom had been identified by Jewish Care as having a formal diagnosis of Alzheimer's type dementia. A gender mix of five (18%) men and twenty-three (82%) women was decided upon at the time the CPCEC research proposal was formulated as proportionately reflecting the overall ratio of men to women in Jewish Care homes. Once selected, the research team made an initial approach to the next-of-kin (or guardian) of each of the residents. At the time that each next-of-kin was approached to give consent for their relative to participate in the study, they were also asked to consent to give an interview for the project.

Once consent from a relative had been given, each resident was approached by a member of the research team, given information on the project and asked to consent to participate. The research team had previously agreed that if either a relative or a resident declined to give consent during this procedure, the resident would not be included in the project. It was agreed by the team that no assumptions would be made with regard to the receptive capacities of participant residents, and as such an effort was made to offer information regarding the project to all those people with dementia selected for the project. Making judgements as to the extent that participants gave informed consent proved difficult. In Phase 1 of the project, eight participants did not communicate verbally in a manner that



we could readily understand. For the remaining nine participants it appeared from our meetings with them that some had a better grasp of our intentions than others, but none explicitly declined to give consent. In a previous study that made use of video filming with people with dementia, the author described some respondents as giving 'uninformed consent' (Cook, 2002, page 213), which seems applicable to some of those participating in the CPCEC project.

Seventeen consents were received, from two men and fifteen women. Of those not included, relatives declined to give consent for three men and seven women, one woman died before the start of the research. A further three women were subsequently excluded after the manager of one residential care facility raised objections to the team conducting research within the home.

The final cohort of 17 residents was filmed in eight separate units within five homes - two dual-registered, one nursing and two residential care. Filming took place between 7am and 7pm with at least one researcher present during these times. Cameras were fixed to the walls of the day rooms of each unit and each resident was filmed over a period of four and a half days (finishing early on Fridays due to Sabbath). Each videotape lasted up to 4 hours with the day therefore divided into three sections; 7am-11am, 11am-3pm and 3pm-7pm. This generated approximately 230 tapes (excluding pilot tapes), recording the day-to-day interactions taking place within the various day rooms.

#### Participant observation:

Two researchers (a colleague and myself) undertook fieldwork using a participant observer approach. In offering an account of participant observation, Denzin (1978) differentiates this approach from complete participation according to the distinction that a participant observer is open as to their identity as a researcher rather than concealing the nature of their presence and activity. In contrast to non-participant approaches, Denzin notes that participant observation positions researchers as better able to make use of their own on-going observations and impressions and as not bound in fieldwork by pre-



judgements about the nature of a setting or a research problem. Denzin also suggests that participant observers are better placed to link the statements and actions of participants.

Openness regarding the researcher's identity and activity is noted as also heightening the possibility of hostile or suspicious responses and reactivity to their presence. This issue of reactivity was a particular concern for the CPCEC project, given the desire to record both in writing and through filming, the day-to-day dynamics and relations of the care settings under investigation. For this reason, the researchers were required to minimise their social engagement with participants and to take on a 'passive' participant role (Vass 1984).

However, on an on-going basis there was a requirement of the researchers to negotiate their 'background' presence with a concern for the ethical standpoint of the project. Given the cognitive and memory impairment of many participant residents, the researchers periodically reminded participants of their presence as researchers and the presence of cameras within the communal day rooms. It was also agreed that at no time would the researchers rebuff or ignore unprompted approaches from staff or residents. Keeping observational diaries in full view during research was also a means by which to signal our presence as researchers.

In order to account for the process of the research and its shaping influence upon the production of data I wish to give a brief retrospective account of my personal experience of participant observation within the CPCEC project.

It is an inevitable outcome of recorded observations that such representations of a setting are selective. Thus, observations are, in themselves, a construct of research and reflect the perspectives and concerns of the researchers undertaking such fieldwork. With regard to observational techniques Angrosino & Mays de Perez (2000) argue

"Each person who conducts observational research brings his or her talents and limitations to the enterprise; therefore, the quality of what is recorded becomes the measure of the usable observational data (because it can be monitored and replicated) rather than the quality of the observation itself (which is, by definition idiosyncratic and not subject to replication)" (page 676, 2000).



In undertaking observation for the CPCEC project, this was my first experience of using such a method. Examining the diaries that I kept during fieldwork offered an insight into the different ideas and impressions that were developed over time as well as my 'learning curve' as a researcher. As an outcome of this development the observations toward the end of the period of fieldwork differed from my early diary entries as thoughts developed and interacted with a growing clarity as to my research practice. In retrospect, it is therefore clear that the quality of my recorded observations evolved over time and was not consistently replicated throughout the study.

Despite being new to participant research my background in dementia care meant that I undertook fieldwork with a prior experience of dementia care settings, albeit under differing conditions. Prior to my employment with the CPCEC project I had worked at various times as a dementia care worker, a social worker for older people and as a support worker for a dementia charity. This background proved to hold both advantages and disadvantages for my experience of research. I embarked upon fieldwork with a conviction that I had a certain understanding of dementia and of the issues related to providing care and support to people affected by the condition. While collaborating in the design of research tools such as interview schedules I viewed my experience as relevant and as informing this process. During interviewing, I found that accounts given by care workers echoed my own experiences and that I could draw upon this experience to better understand these accounts. It was my impression at the time that I had a point of connection or common ground with care workers participating in the project.

In retrospect, I realise that I was, at times, open to reading and judging accounts from respondents according to my own experiences, thereby interweaving their reported experiences with my own recollections of care work. This process undoubtedly shaped my encounters with care workers and my reception of the views and experiences they indicated during interview and conversation. My prior experiences of the field also gave me an unwitting agenda when undertaking fieldwork, I already had notions of what I should look for based upon what I considered to be significant features of a residential care setting, with clear implications for the recording of observations. Having worked in



dementia care I already had an 'interpretative repertoire' (Potter, 1996) on which to draw, this was demonstrated in my diaries. In my early entries I made use of a variety of medicalised terms alongside the use of headings and labels drawn from social work practice in describing what I saw and accounting for it.

In an account of the participant observation method, Denzin (1978) notes that research participants often seek to place researchers within recognisable 'roles'. There is a need therefore to be clear about one's identity as a researcher and to be fully cognisant of the boundaries of this position. As a number of experiences throughout my time in the field demonstrated, my presence as a researcher was under constant negotiation while undertaking fieldwork. At various times both residents and staff sought to include my colleague and myself in the day-to-day workings of the home. Residents sometimes called upon us for assistance, perhaps indicating an impression of us as care workers or helpers. Members of staff also at times asked for our input and on each occasion such requests were politely refused. In conversation with my (female) colleague it was notable that she was called upon to assist on more occasions than I was and it is pertinent to speculate whether our gender was an influence upon this.

A number of times my colleague and I were asked by residents whether we were Jewish and on occasions when residents asked for my surname I wondered whether this was an indirect inquiry into my cultural identity. I lost count of the number of times that residents asked me whether I was married and this highlighted the importance of family, within the care home settings and the concern to socially 'map' new arrivals within familial networks. As a gay man it also highlighted for me the potential issues arising for gay and lesbian residents and for those who may have no families within such a family-oriented social environment. It was also significant that many residents offered advice to my colleague and myself about a range of issues, based upon their life experience. On such occasions, it appeared that age was a salient factor mediating these conversations.

Particular experiences that served to clarify my presence as a researcher were those occasions when I witnessed poor quality care and the outcomes of this for individual



residents. On such occasions it proved difficult to remain detached from unfolding events and at early points in the research I become inappropriately involved by intervening when witnessing residents in distress. These events also highlighted for me the emotional labour of research, something that I had neither fully anticipated nor been prepared for. Despite having trained in research methods at no time did this training incorporate an attention to the emotional challenges inherent in research practice. In subsequent discussion of these experiences the research team incorporated a 'debriefing' session within each team meeting to offer an opportunity to discuss and explore the emotional dimension to the research experience.

Another source of learning during fieldwork was the opportunity it offered to critically appraise my own past working practices. For example, while reading through social work reports and placement reviews in care files for residents I gained a growing realisation of how the language and headings of such reports shaped perceptions and management of encounters with people with dementia. Over time I came to recognise social work discourses as providing a particular 'way of knowing', oriented to questions of need, symptoms and impairment and organised according to the logic of providing care packages.

A revelatory experience during fieldwork was the requirement to sit for six or seven hours at a time in the corner of day rooms and observe the unfolding events. Despite having visited care homes on hundreds of prior occasions during my career, I had always done so with a specific purpose and for time limited periods. It was only when sat observing that I gained a more direct insight into the experience of time and space from the perspective of those who resided in care. Across all the homes visited for the CPCEC study I observed as residents sat idly for long hours, drifting in and out of sleep. The heat and lack of ventilation of many of the settings would often induce drowsiness, a sensory experience that is often overlooked within observational studies.

My experiences of fieldwork as a participant observer and the diaries produced during this time highlighted a number of key issues of pertinence to the present study. The diaries



represent a written account not only of the development of ideas and impressions over time but also the growing insights I gained into the practice of research and the negotiation and management of a researcher identity in a care setting. As indicated above, my relationships to project participants were undoubtedly mediated by such issues as gender, 'race', class, sexuality and age as well as my status as a researcher. However, I also came to understand how my particular history and previous work experiences were a key influence upon how I engaged with the research setting. As such, my interpretations and recorded observations reflected a complex set of interactions, highlighting the importance of attempting to account for these in the writing up of the research experience.

Of particular significance is the experience I had of growing in confidence and competence as a researcher during the period of fieldwork and through this developing a more critical perspective on the culture of social care from which I had come. The manner in which I viewed the care settings under investigation, the nature of the events that I chose to record and the way in which I recorded them, all altered over time. I became increasingly critical of the medicalised terms that I had previously utilised, recognising the implications of such labels and the ideologies of ageing and disability implicit within them. Such change demonstrates the importance of understanding research methods as fluid and by no means fixed in respect to what is done and how research is undertaken.

#### Interviewing of care home staff:

Interview schedules were designed following the completion of a review of existing research in the field of dementia and dementia care. The review focussed upon social research, paying particular attention to investigations that addressed issues of communication, interaction and relations between people with dementia and those supporting them.

The interview schedule for care workers was divided according to a number of headings. These included profile details on individual respondents and details of their working history, respondents' perspectives on and experiences of communication and dementia



care. Interactional issues, including levels of communication and differing aspects of verbal and non-verbal communication were also addressed. Questions regarding the social relations of the care setting, views and experiences of the care environment and working conditions were also included. In respect to the present study, a number of questions were inserted into this interview schedule that specifically addressed issues of gender and sexuality. The interview schedule included, in all, 54 questions, the majority of which were open-ended. During fieldwork, interviews were found to last, on average, for 45 minutes, but with a margin of variation of between 20 minutes and one hour and 40 minutes.

Whilst the schedule was designed to cover a comprehensive range of issues relating both directly and indirectly to communication and interaction, consideration was not given during the design phase to the circumstances under which the interviews would be carried out. This proved to have a considerable influence upon the time taken and length of responses given by interviewees. Workers were interviewed whilst on shift and were therefore removed from their work for the duration of the interview. This meant that workers were required to take time out from their work under conditions where there were multiple demands upon their time. It is therefore important to recognise the nature of this contribution made by participating workers and of the support received more widely, from colleagues, who covered for them during their absence.

#### Coding:

All interviewees were offered the option of declining to answer any question they chose not to and to end the interview at any time. Only on rare occasions during fieldwork was the option to pass on a question used; none of the interviewees terminated their interview. Attempts were made to clarify questions or to use prompts to illustrate questions where useful, however, some respondents misinterpreted a small number of questions. Certain respondents also gave specific answers using examples of individual residents or incidents that made classifying their answers difficult. In a number of cases specific questions were also inadvertently missed out when conducting the interviews. As such, missing answers



or responses that were considered unclassifiable have been classified as 'missing information' and the number of missing responses has been given in brackets. The percentages given for each answer represent a percentage of the number of actual responses, rather than the overall number of interviewees. With regard to respondents codes: rh = residential/nursing home, a-1 = home code, c = care worker, nc = non-care worker, 1-32 = respondent number (1-6 for non-care workers), f = female, m = male.

The interviewing process:

A central concern for this chapter is a consideration of the interaction of theory and methods, in recognition that particular approaches to a field of investigation will generate certain ways of understanding it. As such it is important to demonstrate the manner in which methods of investigation are aligned with the theoretical perspectives employed and explored throughout the study. The present study, which takes a discourse analytic approach to the dementia care setting has a dual concern to generate evidence of the gendered features of this environment whilst appraising the status of this evidence. It is therefore necessary to operate reflexively, and to interrogate not only the content and substance of data but also the processes by which data are produced.

With regard to the interviewing conducted for the CPCEC project and upon which this study draws, ensuing chapters will engage with and discuss the content and characteristics of responses given during interview. However, in order to think critically about these responses it is useful to preface the proceeding discussions with an attention to the interviewing process as a particular mode of producing accounts of the dementia care setting. It is therefore pertinent to ask what type of social event or encounter an interview is; what factors may influence the production of responses; what kind of knowledge or evidence these responses represent; and what claims may legitimately be made based upon them.

Despite the common and widespread use of semi-structured interviewing techniques within social research considerable variance in opinion exists with regard to what



interviewing is able to demonstrate in relation to a particular social setting, situation or event. As previously noted, a unifying thread within differing forms of discourse analysis is a concern to problematise the notion of objective truth and thereby to question the existence of a single, coherent reality when conducting research. It is therefore important to consider the issue of standpoint, the manner in which any individual has a necessarily bounded and partial knowledge based upon the limits of their own experience. Alongside this, attention must be given to the many layers that exist between subjective experience and the production of an account of that experience and beyond this to the manner in which analysis of these accounts represents a further refraction of that experience.

Fielding (1993) notes that an important feature of the interviewing method is the possible influence of the relationship of an interviewer and interviewee and in particular their respective identities and relative social proximity.

"As well as race, characteristics such as age, sex, social class and religion have proven to have an impact which has to be allowed for" (page 145, 1993).

Such a concern with the potential influence of the identity of the interviewer is of pertinence to the present study. For example, the majority of interviews with care workers were conducted by myself; a white, middle class man, while approximately one third of the interviews were conducted by my colleague, an Asian, middle class woman. The majority of respondents for this tranche of interviews were Black and minority ethnic women, many of whom were first generation immigrants. The question of interviewer effect was particularly significant given that carers were asked specifically to address issues of gender, sexuality and cultural difference during interview. As such, it may be argued that these aspects of identity and the associated social differences between interviewers and respondents were made salient during interview as a result of some of the questions posed.

In light of these social differences and the associated imbalances of power embedded within them, a number of feminist commentators have argued that male interviewers are at a disadvantage when interviewing women.



"However effective a male interviewer might be at getting women interviewees to talk, there is still necessarily an additional dimension when the interviewer is a woman, because both parties share a subordinate social position by virtue of their gender. This creates the possibility that a particular kind of identification will develop." (Finch, 1984b, page 76)

A number of questions arise from this stance. Firstly, it may be argued that an assumption of a 'particular kind of identification' prioritises gender relations whilst overlooking a variety of other aspects of social difference with regard to factors such as 'race', age and class. It also overlooks the question of how more localised and interpersonal factors may mediate an interview situation. Furthermore, such a stance assumes that gender will have a generalised and knowable outcome for the responses elicited within an interview and the relationship of interviewer and interviewee. Such an assumption was laid open to question according to the interviewing process for the present study. While variance existed between individual interviews on a variety of levels, when comparing the interviews with care staff conducted by my colleague and myself, there were no identifiably consistent differences with regard to response length, topics raised or the standpoints assumed by respondents during interview.

Through an expansion and substantial elaboration of the notion of 'interviewer effect', Holstein and Gubrium (1997) have argued for the need to understand interviews as sites for the production of meaning. They propose that an interviewer is inextricably implicated in the production of responses and works with an interviewee in this process, with interviews thereby representing a 'special form of conversation' (page 113, 1997). Such a perspective suggests a view of the interview process as a fluid and negotiated dynamic, mediated by a range of interpersonal and situational factors, with any response representing a collaborative and co-constructed outcome of this dynamic.

The question therefore arises as to the extent to which any generalised statements can be formulated with regard to the possible 'effects' of social difference. Not least when considering the range of possible mediating factors that may shape the production of responses during interview. The, at times, marked differences between individual



interviews highlighted the importance of attending to divisions and even conflict within any group of interviewees, a concern that is often overlooked when seeking to identify patterns or characteristics across a sampled population. It is therefore useful to explore the interviews themselves in order to offer an account of the wide variety of influences upon the conditions and circumstances of production.

With regard to the interviews conducted with care workers, it is pertinent to note that a survey administered by Jewish Care to all care staff seeking their views on issues of communication within the organisation achieved a 17% response rate. In contrast, the CPCEC project achieved a response rate of 36% for care workers consenting to participate in the first phase of the project. Such a comparison may indicate that a perception of the research team as independent of the host organisation was one influence upon care workers' willingness to participate.

An issue arising from the interview process is the question of the extent to which responses given during interview were influenced solely or largely by the interviewer as audience. In other words, can it be assumed that the relationship of interviewer and respondent is the primary or most influential relationship that mediates the production of responses? For example, as a preface to critical or negative comments, a number of respondents asked for further re-assurance as to who would have access to interview data and the issue of anonymity when quoting from interviews. Such concerns suggest an attention to the respondent's relationship with their employer and the possibility of the organisation as an audience or 'over-hearer' of what was said during interview.

Another issue arising from interviews was the variance in the 'voice' employed by respondents, in other words, the manner in which respondents invited the interviewer to view their status or standpoint during interview. It may be argued that each batch of interviews offered or constructed a standpoint from which respondents were invited to speak, i.e. that of carer or relative. However, such standpoints proved to be negotiable during interview. For example, some care workers used 'we' rather than 'I' when offering an opinion or account of events suggesting that they were speaking as members of a



collective, perhaps as spokespersons for the wider body of care workers or as authorised representatives of the organisation for which they worked. Such shifts in positioning highlight the fluid nature of the relationships that are called upon during the interview process and the problems therefore associated with assuming particular effects based upon a stable relationship or dynamic between interviewer and respondent. The interviews demonstrated that a number of standpoints were open to respondents, and as Holstein and Gubrium (1997) have noted, respondents 'continuously monitor who they are in relation to the person questioning them' (page 122, 1997). Thus, respondents constructed and reconstructed their subject positions while speaking.

With regard to interviews with care workers, it is possible to identify a number of potential positions, including that of care worker, care worker representative and that of an individual (man or woman) speaking of their views and experiences of the care setting. Interestingly, responses revealed that such positioning shifted during the course of an interview suggesting the importance of paying attention to each interview as a whole rather than focusing solely upon the collective responses given to particular questions, in order to map this repositioning.

A useful concept to draw upon when considering the variety of factors mediating the production of responses during interview is Goffman's (1967) notion of 'face'. Goffman has argued that social interaction is structured or ordered according to a variety of interaction rights and obligations and that interactants engage in face-work as a condition of interaction:

"The term face may be defined as the positive social value a person effectively claims for himself by the line others assume he has taken during a particular contact.' ... 'A person may be said to have, or be in, or maintain face, when the line he effectively takes presents an image of him that is internally consistent." (Page 5/6, 1967)

On a number of occasions respondents explicitly attended to face when offering a response to questions, in particular when seeking to ensure that their comments were perceived as consistent with the subject positions from which they spoke and not



attributed a negative interpretation. These moments during interview are of particular significance in highlighting the interactive work that a respondent engages in when constructing a response.

Also of note from the interviews was the manner in which the various positions or standpoints from which respondents spoke, shaped the presentation of a consistent self-image. For example, certain rules may be argued to apply to what may or may not be said when speaking as a carer:

"No nurse would have felt happy about complaining that a patient wanted too much care, but it was legitimate to complain about an overload of physical tasks, or tasks inadequately carried out" (James, 1992, page 499).

It may therefore be argued that in asking respondents to speak in their capacity as carers, the interviews set certain parameters as to what might be said and how. Part of the interactive work in which respondents engaged was therefore to find ways of offering accounts that observed these parameters. For example, when voicing criticisms of individual residents, some respondents shifted their positioning from 'carer' to a more personalised and individualised standpoint.

Arguably, of particular relevance to the present study is a consideration of the wider investments associated with taking up and speaking from a particular standpoint. Thus, given wider societal associations of caring and femininity it may be argued that when (female) respondents offer accounts of themselves as carers such narratives carry implications regarding the representation of a gendered identity. It is therefore pertinent to speculate upon the potential significance of being seen to be a competent and capable carer given the manner in which such an activity is interwoven with a feminine identity. In contrast, for male carers it is important to consider what implications are associated with speaking as a carer given a wider social association of caring and femininity. These considerations will be addressed in greater detail in ensuing chapters, given their pertinence to the present study.



It is therefore clear that interviews create a range of conditions for the production of responses. Respondents offer accounts of their experiences and narratives of self according to a number of concerns and aspects of interactive 'work'. In addition to attending to the interviewer as audience it may be argued that a number of further assumed or imagined audiences are a concern for respondents when speaking. The notion of face highlights the influence upon respondents in organising their responses in a manner that is perceived as consistent with particular standpoints. In this way, certain standpoints serve to 'script' responses. However, as has been argued, these standpoints are open to re-negotiation during interview and this highlights the problems associated with attempts to demonstrate or control for discrete effects of the interviewing process and an interviewer-respondent dynamic. As such, it may be argued that differing aspects of the interview relationship become salient at different times according not least, to the standpoint or 'voice' employed by respondents. Both interviewer and interviewee may therefore be usefully understood as engaging in a particular form of social performance.

#### Textual analysis:

In a discussion of textual analysis, Silverman (2000) defines a text as "data consisting of words and images that have become recorded without the intervention of a researcher" (page 825, 2000). This broad definition offers an applicable notion of text as it is addressed in the present study. A range of documents and records were included as part of the textual analysis of the care setting and wider organisational environment, highlighting the many audiences with which Jewish Care engages and the variety of media employed to do this. Examples of such texts include the promotional literature produced to provide a source of information to prospective service users, the in-house newsletter distributed to all staff, and fundraising advertisements in the Jewish press. Jewish Care also has a website that performs a number of functions; it is designed to be accessed by and relevant to a wide and varied audience including potential donors, volunteers, service users and those contemplating employment with the organisation. The audiences to which the website and other texts 'speak' thereby offer an insight into the range of stakeholders either directly or indirectly associated with Jewish Care. As previously noted, the CPCEC



project was also offered full access to all documentation held on each of the residents participating in the project.

This variety of textual sources offered an opportunity to explore the ways in which Jewish Care was represented as an organisation whilst highlighting the network of communicative channels and interactions that existed both within the organisation and with a wider social context. Each text therefore offered insights into the points of connection between groups and individuals within the organisation and the wider relationships fostered by the organisation as a whole. In keeping with the overall analysis of data across the study, three main research questions were addressed to the texts incorporated within the study. Alongside a consideration of content, attention was given to the representational 'work' that each text performed and the interpretative resources drawn upon in their construction as well as the resources they offered for interpretation.

A variety of interactions are inscribed within a text and serve to produce it. As such, Smith (1990) challenges the treatment of texts as inoperative or uncontexted, which she describes as the 'inertia of the text' (page 120, 1990). Rather a text should be understood as a constituent of social relations.

"The text itself is to be seen as organising a course of concerted social action. As an operative part of a social relation it is activated, of course, by the reader but its structuring effect is its own" (page 121, 1990).

Hoey (2001) notes that a text is structured according to the requirements of an author and the needs of an audience. Author(s) and reader(s) are arranged both in relationship to one another and with the text itself and a variety of factors mediate these relationships. Thus, Atkinson and Coffey (1997) highlight the manner in which a text is produced according to a particular genre or 'restricted code' (page 54, 1997), dictated by its purpose and implied audience. The structure of a text is also shaped by the purpose it is designed to serve while its composition invites ways of reading and using it. Thus, Hoey (2001) differentiates narrative texts that are to be read from beginning to end from colony texts, wherein component parts may be read and understood without reference to the whole.



The genre or conventions of a text set conditions for authorship but also have requirements and outcomes for readers. For example, a certain cultural knowledge may be required in order to access and make sense of a text and it may therefore be most readily understood according to a particular perspective or standpoint. Drawing upon a Foucauldian perspective, Prior (1997) emphasises the need to attend to the genealogy of the genres or discourses that constitute a text and the manner in which such a genealogy highlights the positioning of a text at a particular point in time.

Issues of ownership also shape the production of texts and the status of their contents. Of relevance to the present study, Atkinson and Coffey (1997) note:

"It is part of the facticity of many official and organisational documents that they are not identifiably the work of an individual author. Their very anonymity is part of the official production of documentary reality." (Page 58, 1997)

Drawing upon sociological critiques of scientific knowledge, Potter (1996) has highlighted the manner in which stake and interest are obfuscated or displayed as absent in the construction of facticity and the importance for discourse analysis of examining how this is achieved.

Of particular relevance to the present study is a consideration of the text as artefact or product according to both its practical usage and symbolic status. Participant observation offered a useful contribution to textual analysis given the opportunity it offered to observe how certain texts were used within each care setting and by whom. Issues of restricted access to particular organisational texts thereby expressed and upheld relations of power within care homes. In addition to their being constituted according to certain interpretative repertoires, texts also serve as interpretative resources. As Diamond (1990) has pointed out with regard to care home documentation:

"Charts define residents in terms of their medical and psychiatric troubles. To read the charts, then, is to get to know the residents better through their sicknesses" (page 181, 1990).



A key concern for textual analysis is the 'representational work' of a text. Hoey (2001) has argued that a number of culturally popular patterns structure a variety of texts, examples of which include a problem solving pattern and a goal achievement pattern. Such patterns signal an internal logic to a text that structures content and the presentation of it. For example, both such patterns had been employed in the care planning literature for individual residents. In earlier versions of the standardised care plan, headings consisted of 'problem - action - outcome', for example with dementia or a symptom of dementia listed as a problem, with a particular intervention then offered as a means to 'solving' this problem. In later versions of the literature this format had been changed to a goal achievement pattern. Thus moving away from a construction of the person with dementia as 'problem' and from a view of certain interventions as offering 'solutions'. Such a change in the documents highlights both a shift in the textual construction of the person with dementia and the genealogical development of the discourse employed within the text.

It is therefore clear that a variety of considerations are associated with the deconstruction of a text. In line with the wider analytical approach to data for the study, it has been argued that texts may usefully be considered as comprised of a variety of interactions, whilst operating interactively. Such interactions exist at the level of content; the interpretative resources that such texts both draw upon and provide; and the representational work they perform in constructing a particular version of the care setting and of the issues and individuals to which they refer. Thus, a key issue for a discourse analytic approach to texts is the concern to reveal how they organise and hierarchise knowledge and through this interact with a wider social context at a number of levels.

#### Video filming:

A key source of data drawn upon for the present study was the video-filming of the seventeen residents, during the periods that each one spent in the communal day rooms of the homes in which they resided. A number of existing studies have made use of video filming when conducting research with people with dementia or other forms of cognitive



and communicative impairment and have highlighted the benefits in so doing. Whilst recognising the benefits of videotaped data, Cook (2002) highlights potential ethical issues associated with the method. Attention is drawn to the vulnerability of research participants given their limited influence over how such data may be used or of who may have access to it and of the dangers of objectifying participants as "members of a diagnostic category with a specific communicative dysfunction" (page 219, 2002).

Couchman et al (1995) found that videotaping preserved the cultural and social context in which events and actions took place when filming interaction within day care settings for people with severe learning disabilities. A further benefit of videotaping interaction and behaviour is the minimisation of interference by the researcher(s). Sandman and Norberg (1988) used video-filming to investigate the changes in behaviour of people with dementia, both in and out of the presence of carers. The potentially intrusive presence of a researcher was overcome through using cameras to record the unfolding interactions.

A particular benefit associated with videotaping, as a method of data collection is the potential for analysis to attend to sequences of action and interaction that may occur simultaneously, including assessment of both verbal and non-verbal interaction. Bottorff and Varcoe (1995) investigated the interaction of nurses and other healthcare workers with patients with a variety of impairments. The authors argued that the capacity of videotaped data to represent events in real-time, maintaining the context in which they occurred, led to the development of a model of communication as dynamic and transactional. Similarly, Hanson (1994b) has argued that videotaping complements an interactionist perspective as it captures both action and reaction within a context, with behaviour therefore not seen in isolation.

Despite the growing use of video-filming as a means of generating data, considerable variance exists as to how such data is analysed and represented. The 'richness' of video filmed data dictate the need for a clear notion of those features that are the focus of analysis; i.e. what is considered to be a unit of analysis. Alongside this inevitable narrowing of focus is a need to find a style of transcription that will best represent the



analytical concerns. As Rose (2000) highlights, analysis and transcription of complex data is a construct of the research process.

"Every step in the process of analysing audiovisual materials involves translation. And every translation involves decisions and choices. There will always be viable alternatives to the positive choices made, and what is left out is as important as what is present. Choice in a multiple field is especially important when analysing a complex medium where translation will usually take the form of simplification." (Page 246, 2000)

A key question for the present study has therefore been how the representation of data may best help in addressing the topic at hand. As previously discussed, emphasis within the study has been placed upon the negotiation of interactions and the meanings that emerge within particular situations and settings. This over-arching concern has therefore shaped the textual representation of the episodes of interaction accounted for within the study:

"Transcripts which present the talk of different speakers in sequence suggest that the analyst is interested in meaning which is created through interaction, that is, jointly constructed" (Taylor, 2001, page 35).

In an attempt to demonstrate the correlation of action with speech, transcribed interactions have been presented according to a grid representing spoken content and certain non-verbal aspects of the interaction. However, this method of transcription, which presents speech in a 'play-script' style, evolved during the study following a number of aborted attempts to address additional aspects of speech. For example, an initial concern to represent the tone of speech, especially as employed by care workers, was later dropped in recognition of a number of concerns as to the validity and reliability of analysing this aspect of communication. Such concerns related to the ethnic mix of care workers and the variety of accents and styles of speech associated with this diversity. Making judgements of tone for the present study, without the benefit of validating interpretations through inter-rater comparison was subsequently deemed too unreliable and overly subjective.

Triangulation:



A triangulated methodology provides the means by which to account for the differing versions of events that may characterise experiences of a social situation or setting. Additionally, it facilitates the appraisal and evaluation of each method through comparison with other approaches taken and thereby enhances a reflexive critique of the research process.

Triangulation for the CPCEC project took place at a number of levels; making use of differing sources of data, differing methods for generating data and at the level of theory through a concern to investigate a number of questions regarding the nature of communication and social relations. The use of two researchers to conduct fieldwork meant that investigator triangulation also informed the undertaking of the wider project. In a discussion of multiple forms of triangulation, Denzin (1978) highlights the benefits to research of such an approach given the opportunities afforded for comparative analysis in supporting interpretations and conclusions generated from research. Denzin suggests that the use of across method triangulation serves to strengthen a study on the basis that the flaws of one method may prove to be the strengths of another.

In a review of a programme of research into the 'informal relationships' between nursing home staff and residents based upon self-reported communication behaviours of the nursing staff, Nussbaum (1990) comments:

"For the most part, conversations between the nursing staff and residents *are* patient-oriented. The most common topics of conversation reported by the nursing staff were: the patient's family, problems of old age, hobbies of the patient, death and the patient's health" (page 162, 1990, emphasis added).

As the above quote indicates, the author treats data generated from interviews with care workers as unproblematic resources for knowing the care environment. The findings of Nussbaum's study closely match those of the CPCEC project, based upon the interviews conducted with care workers. Significantly however, within the CPCEC project considerable dissonance was found to exist between care worker reports of the nature and



substance of communication and that recorded during the video filming of the homes under investigation and during participant observation. Such dissonance underscores the importance of questioning the status of evidence generated.

A key feature of triangulation is that the researcher is placed in a 'birds eye' position with regard to data, and such a perspective allows for the identification of divergent and convergent features across differing bodies of data. However, as Perlesz and Lindsay (2003) have argued: "the research literature on triangulation has paid little attention to the problematic of 'making sense of dissonant data'" (page 26, 2003). From a discourse analytic perspective, the concern to problematise objective truth raises questions of how dissonant data are viewed, and highlights the wider issue of the epistemological status of any piece of data. Such concerns return this chapter to the opening discussion of how certain key features of discourse theory may drive analysis. At the same time they create a useful opening for the ensuing chapters.

Firstly, a questioning of the presence of a single and coherent reality or truth that is accessible through social research raises ontological issues with regard to what may be understood to exist beyond, or outside of discourse and the extent to which it may be accessible or knowable. This leads into the question of what status any body of evidence has when generated from a particular group or source within a given setting. It is a defining feature of discourse analysis that accounts and descriptions of a social setting or phenomenon are treated as the topic of critical attention, rather than serving purely as an explicative resource. Such an 'emic' view of social phenomena leaves open to question what lies beyond these processes of representation.

Finally, when faced with dissonant data, the issue of what claims may legitimately be made based upon this evidence and how such claims may be validated implicates the researcher. A number of stances are open to the researcher, including the possibility of 'taking sides', perhaps in alignment with disempowered groups or perspectives. However if, as previously argued, power is taken to circulate and to have a capillary presence within social relations then judgements as to the location of power may be problematic.



Alternatively, in eschewing an exercise of power through the application of judgements and critical evaluations of participants' accounts or versions of events, the researcher is open to a charge of relativism.

## CONCLUSION:

As a preface to the analysis and discussion of data, this chapter has sought to outline the shaping influence of the methods employed by the study. It has been argued that the manner in which a topic of investigation is approached serves to produce certain ways of seeing that inevitably rule out alternative perspectives or forms of knowledge. Emphasis has been placed upon a personal experience of undertaking research as a dynamic and evolving process. In this respect, a researcher's identity has been argued to be crucial to social investigation while the importance of a range of biographical, relational and situational factors have also emerged as significant influences upon the ways in which sense has been made of the settings under investigation. Importantly, the interactive nature of research has been underscored. The ways in which the research experience challenged and altered my assumptions and interpretations led to a need to re-think and re-position my standpoint during the period of the study.

This chapter has set out two, parallel but connected concerns that are woven throughout the study. Firstly, I have signalled my intention to consider the constructed and constructive quality of the accounts and representations that are a source of investigation. Thereby, not only to consider the meanings of such representations, but also to address the mechanisms by which meanings are themselves produced. Secondly, such an endeavour inevitably requires a questioning of the status of the evidence that is generated. As such, there is a need to consider the limits upon what claims might be made. In other words, this study both produces and explores situated knowledge.



## **4. HIERARCHIES OF IDENTITY - PART ONE**

### **History and context**

#### **Introduction:**

A guiding concern for this chapter will be to explore social hierarchies and their situated construction. As a theme, the notion of hierarchy performs two functions. Firstly, it prompts consideration of the different standpoints and experiences within social settings and institutions. Secondly, it structures the representation of social relations, focusing the proceeding analysis upon an attention to differentiation. An on-going consideration will therefore be to problematise the unifying function of certain key terms and categories employed throughout the study to describe the various groups who live and work in the care settings under investigation. The purpose of this is to demonstrate the elliptic quality of such categories and to underscore the omissions that any attempt to generalise inevitably entails.

A Jewish identity is a shared and common attribute of all those residing in Jewish Care facilities. It is the primary qualifying criterion for access to the organisation's services and support. According to Jewish Care's own promotional literature, a concern to support a Jewish identity is a priority of the care on offer. Thus, 'Jewish' functions discursively to collectively identify those in receipt of care and support, while at a concrete level it serves as gate-keeper to Jewish Care's services.

Contemporary accounts and histories of the Jewish community in Britain are similarly shaped by a focus upon this shared aspect of identity, although, at times, 'Jewish' seems a problematic term, cited variously as an ethnicity, culture and faith. There are circumstances where, what it is to be Jewish is open to debate, or contested. According to Jewish law (halakhah) a Jew is someone born of a Jewish mother or else converted with the recognition of an Orthodox authority. The growing numbers of Jews who are marrying



outside of their community (currently one in three marriages), and those who have no formal affiliation with a synagogue serve to test the boundaries that define the community.

For the present study an early inconsistency noted during fieldwork was the absence of any comprehensive social and biographical information held on residents of Jewish Care's homes, despite the organisation's stated concern to support client's identities. While limited training is offered to staff on a 'Jewish way of life', no readily accessible details on the histories of Anglo-Jewry or wider accounts of the make-up and characteristics of the community seemed to be on offer. Few identifiable opportunities existed for staff to explore the lives and histories of those with whom they worked. Such conditions also presented a particular challenge to the present study in seeking to gain a perspective on the lives and backgrounds of those participating in the project.

Of the limited biographical detail gathered by the CPCEC project, at least ten participants were known to be from London, the majority specifically from the East End and at least four of the 15 women in the study were known to have been involved in the dressmaking and tailoring trades. Three other participants were known to have emigrated from Europe, either shortly before or during the Second World War. The random selection of participants heightens the likelihood that their social backgrounds and origins are representative of the overall population of Jewish Care residents. Existing research has noted that many older people currently residing in Jewish-run residential care represent the first generation of English-born Jews, whose families originated in Eastern Europe (Valins 2002).

#### Jewish Care:

Jewish Care was formed in 1990 by the merger of the Jewish Blind Society and the Jewish Welfare Board (formerly known as the Jewish Board of Guardians). It has subsequently expanded to incorporate nine smaller Jewish groups and organisations and currently offers support and services to an estimated 7,000 clients. State funding is an important source of income for Jewish Care; overall, central government now provides approximately 60% of



the operating costs incurred by Jewish welfare agencies, amounting to about 30% of their total income (Alderman 1992). The largest of a number of Jewish voluntary sector organisations, Jewish Care has close links with the Jewish community. The organisation is supported by donations and fundraising, largely within the Jewish community and further benefits from the input of 2,500 volunteers. At a recent Golden Anniversary Campaign Dinner, £6.3 million was raised in the course of one evening, offering an insight into the level of support the organisation is able to mobilise. A survey of nearly 3,000 Jews in London and the South-east found that Jewish Care was the single most popular recipient of charitable donations for respondents (Becher et al 2002). Of these donations, the survey found that 80% of the total amount was given by only 9% of the sample, highlighting the charity's reliance upon a small but wealthy minority within the Jewish community.

Jewish Care maintains a profile through regular advertisements in the Jewish press. Image 1 (Appendix 1), (carried by the Jewish Chronicle) offers an example of such fundraising adverts. The advert depicts a younger man embracing an older woman accompanied by the text 'Our way for generations has been to support and sustain each other'. The advert alludes to the centrality, within Judaism and Jewish culture, of the family and of kinship ties. It also signals the tradition of charitable giving and philanthropy that have played a key role in maintaining the community. This tradition of charitable giving has roots within Judaism. "According to Jewish tradition and 'halakhah' (Jewish law), charity is considered one of the cardinal 'mitzvot' (good deeds) of Judaism" (Valins, 2002, page 19). An image of the Jewish community as supporting itself also carries a political message, one that encourages a perspective upon the community as independent and 'self-helping' whilst emphasising unity and consensus.

As an organisation, Jewish Care interacts with the wider community at a number of levels. Through a requirement to fundraise and attract support it contributes to the construction of contemporary Anglo-Jewish identities and plays a central role in the representation of service users to a wider audience. In order to consider the manner in which care homes both reflect and uphold the relations of the wider community it is useful to outline the



cultural and historical context and the shaping influences upon the organisation and its relationship to service users.

### Constructions of Jewish history:

Accounts of the history of Anglo-Jewry have highlighted the importance of charity and philanthropy to the community in sustaining itself and of the consequent links between differing strata of the community through this support (Alderman 1992, Green 1991, Prochaska 1980, 1988, Tananbaum 1997). This tradition of charitable giving has contributed to representations of the Jewish community framed by a model of social consensus.

"Rich and poor alike, newly immigrant or indigenous already for generations, Jews were united through their past.' ... 'All knew instinctively that, irrespective of economic status, ethnic or racial background, differences of language or of ritual, the steadfastness of any Jewish community in a foreign land was in the interests of all." (Green, 1991, page 178)

However, such representations warrant scrutiny, not least because the emphasis placed upon commonality through a shared faith and cultural identity downplays intra-community difference and division.

### Charity and philanthropy:

It is useful to consider the emergence of a charitable network within the Jewish community and the forces that shaped its development, given Jewish Care's contemporary status as a charity. Whilst Jewish Care's current form and identity is a relatively recent development, arising from the amalgamation of various smaller organisations, its roots are located in the expansion and consolidation of a welfare infrastructure during the nineteenth century. As will be discussed, this has implications for the relationship that Jewish Care enjoys with the wider Jewish community, and offers insights into the relations of class, culture and gender that are embedded within this relationship.



Throughout the nineteenth century, successive British governments took a largely non-interventionist stance with regard to the Jewish community. Little, if any formal state support made particular provision for Jewish recipients. Tananbaum (1997) argues that a fear of exacerbating anti-Semitism also influenced the development of intra-community support in the form of a range of welfare organisations. From the outset these organisations were reliant upon donations from an affluent minority. As Rozin (1999) points out, in accepting the support and assistance of an affluent elite, poorer Jews were required to accept their authority.

Two important outcomes of this welfare network, which have subsequently shaped the provision of support and care to the Jewish community, were firstly, that Jewish welfare provision was effectively racially segregated. Secondly, that in concentrating resources and influence upon intra-community support, such provision arguably did little to progress the inclusivity of mainstream public services in relation to minority groups and communities.

#### Gender and Jewish history:

Of the few existing historical accounts of the Anglo-Jewish community there has been little direct attention given to gender relations (Marks 1992). One outcome of this has been the under-representation of women in constructions of Jewish history. Their specific contribution to the community and their regulation and subordination are largely absent from accounts of 'the Jewish experience' (Burman 1990). Within representations of Anglo-Jewry a masculine standpoint has therefore often been presented and treated as the community norm, arguably in service to a consensus model of the community. That femininity may serve to disrupt and problematise a coherent Jewish identity and narrative remains largely overlooked.

However, in universalising a masculine experience, (Jewish) masculinities are rarely explicitly addressed or theorised with little consideration given to men as gendered individuals. A unified category of 'Jewish' within histories of the community has also



underplayed the connections of gender with other aspects of identity and social experience. Whilst the Jewish community has been shown to be divided according to factors including class (Rozin 1999), gender (Burman 1990, Marks 1990, 1992, 1994, Baker 1993) and age (Kosmin and Grizzard 1975, Kosmin and Levy 1981), scant consideration has been given to the manner in which these factors intersect, creating particular standpoints and experiences of 'Jewish-ness'.

#### Immigration:

Experiences of mobility are a prominent characteristic of the Anglo-Jewish community. The history of the Jewish community offers particular insights into the various dimensions of mobility including the interplay of both concrete experiences of movement and of social advancement associated with the increasing affluence attained by sections of the community.

The growth of the Anglo-Jewish community is characterised by waves of immigration. The greatest expansion of the community took place during the mid and late-nineteenth century<sup>1</sup>. Accounts of this period of immigration and rapid growth are characterised by narratives of a unified experience of exodus and re-settlement. Limited attention has been given to the variety of motivations for migrating or the differing impact, according to factors such as gender, of settling in host countries.

The male 'pioneer', establishing himself in a host country and serving as the anchor for a process of chain-migration, whereby families and whole communities were to follow, is a common image in much of the literature on Jewish migration (Alderman 1992, Green 1991). Despite this, Friedman-Kasaba (cited in Sharpe 2001) has noted that migration offered young single Jewish women the opportunity to make a free-choice marriage and to distance themselves from their families, thereby limiting the exercise of paternal authority. As Sharpe (2001) has argued with regard to migrant communities in general:

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<sup>1</sup> Largely as the result of the restrictions placed upon Jews in Russia and their persecution during the pogroms an estimated two and a half million migrants settled in Britain, the majority in London's East End.



"Not only have women proven to be seen to be essential to the community-building process, migration itself has been seen as the terrain where gender relations are renegotiated. Women's agency as household workers, consumers and care-givers is essential in adjusting past experience to present reality" (page 21, 2001).

As such, experiences of mobility underscore the fluidity of gendered identities and relations. Morokvasic (1983) has argued that studies of migration have failed to offer any comprehensive account of migrant women's specific socio-cultural background and thereby lack any definition of migrant women as a category of analysis. One outcome of this oversight is that the gender relations and inequalities underpinning the process whereby the Jewish community was established and subsequently thrived within London remain hidden.

"A good deal of attention is paid in this literature to the way in which 'resources' available within a specific ethnic group are used to create alternative employment structures or a specific economic niche for migrants and 'their families'. I believe that the major flaw in this literature is to play down or ignore the fact that this petit-bourgeois class position can usually only be achieved through the exploitation of other migrants, particularly female 'kith and kin' (Phizacklea, 1983, page 109).

Thus, while gender relations were a key factor in Jewish social mobility this has often been obscured within historical narratives by the employment of unified notions of family and community. Such representations veil the social and economic contributions of women not least through an inattention to the 'private' domestic setting and the divisions and differing interests inherent within family structures. It is therefore clear that certain constructions of the family have had a crucial influence in promoting a coherent historical narrative and community identity.

Networks of influence:

The development of an infrastructure to the Anglo-Jewish community is characterised by exclusions according to gender and class. Throughout the eighteenth and nineteenth



centuries synagogues relied upon contributions from an affluent elite and for this reason there were close ties between the community's religious leadership and a wealthy minority. Membership of the large London synagogues was secured through seat rental, thereby precluding formal affiliation by the poor and working class, consequently denying them any voting rights or responsibilities (Rozin 1999). Additionally, as Alderman (1992) points out;

"Orthodox Judaism accords almost no role in formal acts of worship to the female sex and no part in the direction of synagogal affairs as a result of rabbinic prohibition on women being placed in positions of authority over men" (page 198, 1992).

Despite membership of a wealthy elite, middle class Jewish women had little direct input into the groups and organisations that held authority within the community. Exclusions from the authoritative institutions within the community based upon class and gender thereby underpinned the emergence and consolidation of a hegemonic perspective within the community.

#### Gender and employment:

An attention to Anglo-Jewish history provides an opportunity to outline a number of overarching themes for the present study and to trace their connection across time and place. One such theme is the exploration of how gender produces experiences of place and particular social domains. It is therefore important to highlight the manner in which connections of identity and place have served to organise the discursive construction of Jewish histories but also the concrete outcomes associated with a gendered division of the public and the private sphere.

Throughout the nineteenth century and well into the twentieth century immigrant and working class Jews were concentrated within the tailored garments industry (Kershen 1988, 1989). Women's work consistently attracted lower rates of pay and they were largely excluded from the Trade Unions (Kershen 1989). The lack of representation for



women as workers was also a result of their work often being less visible. Once married women were expected to be home-based. For many poorer families, this rarely led to wives giving up paid employment, but rather a relocation of work to a domestic context. It has been argued that this invisibility of women's work has been perpetuated in histories of the community, with limited investigation of women's employment experiences informing accounts of the working lives of Jews in the UK (Burman 1990). However, it is clear that for many working class Jewish women home and employment were interwoven.

#### Gender and home:

Marks (1992) has argued that within historical accounts of Anglo-Jewry, the discursive imposition of a division of home and work has created a series of oversights. For example, the perspectives and contributions of single Jewish women have received little explicit consideration and there has been an almost complete absence of consideration given to Jewish masculinity in a domestic context. A stereotype of the 'good mother' has also served to veil the experiences of those who challenged such idealised notions, for example deserted wives and unmarried mothers (Marks 1992).

The gendering of place and space also appears to have obscured the interactions of men and women, as a key dimension of gender relations. Studies that have mapped the social mobility of the Jewish community and the consequently changing positions of women and men have overlooked how such reconfiguration was negotiated at cross-gender and inter-generational levels. While affluence often led to women refraining from paid work little is known of how this impacted upon intra-family relations. Burman (1990) notes that considerable difference in the responsibilities and expectations of women emerged from one generation to another, often as the result of increased affluence. This would indicate a fluid and negotiated experience of gender and yet this 'gender mobility' has been largely ignored, often underplayed due to fixed and static notions of gender, tied to a public/private dichotomy.

#### Britain and the Holocaust:



World War Two reconfigured international relations and national identities. The displacement of millions of Jews as a result of the Holocaust led to another period in Jewish history characterised by mass migration. This was exacerbated by the refusal of asylum in many European states. Despite a growing awareness of the scale of Nazi persecution and execution of the European Jewish population, Britain refrained from taking responsibility or action to alleviate suffering (London 2000). On the domestic front, the response to a potential influx of large numbers of displaced Jews was characterised by a concern that a Jewish immigrant presence would fuel anti-Semitism and public disorder. Based upon an analysis of policy and legislation documents and correspondence from wartime and post-war Britain, London (2000) has argued that the British response to the Holocaust was shaped by self-interest.

The post-war period was a key point in the further development and consolidation of an exclusionary immigration policy serving as the origins of current refugee and asylum legislation. Jewish immigration was treated as an opportunity to fill certain labour shortages, thus, severe restrictions were placed upon Jewish immigrants entering Britain. Those who gained entry met with tight regulation upon their access to work and education. London (2000) notes that many refugees were classified as economic and racial immigrants, thereby devaluing their claims to asylum. Many female immigrants were granted admission to Britain on the condition that they worked as domestic servants. In granting temporary status to many refugees, this served as a form of control and management, pushing them into certain types of work.

#### Social mobility and suburbanisation:

Following the end of the war, the geographic dispersal from the East End continued, laying the foundations for the current distribution of the Jewish community across London. Areas of north London and outer-London, such as Golders Green, Barnet, Hackney, Redbridge and Enfield attracted large numbers of socially and geographically mobile Jews. However, this movement was by no means indicative of the whole



community. Those making the move to the suburbs were generally the younger, economically active members of the community.

The spread of families served to reconfigure inter-generational relations as the traditional networks of support within extended families were replaced by nuclear family units. At the same time the make-up of the traditionally Jewish East End underwent gradual change. The maintenance of an observant lifestyle was gradually undermined by the disappearance from the area of many Jewish services and resources, including shops and synagogues.

Recent history and the contemporary context:

"The Jewish community has changed hugely since they (community centre attendees) were young and growing up here, you know. They've seen the community prosper and move on, so the only community that is left in this area now, the only Jewish community I mean, is the elderly one. So they are living in a block where they may have had many Jewish neighbours at one point, but now they have none. They've seen the, I mean the immigrant population has changed so they have many neighbours, um, from different cultures, that they don't particularly think they relate, and, um, as we all know people are out at work. Neighbours don't know neighbours quite as well as they used to, when they were growing up. So for that reason, as well, I think they are particularly isolated, very few have families living nearby" (Community centre worker interviewed for the CPCEC Project).

Studies of suburban Jewish populations have highlighted the importance of attention to divisions within the Jewish community. Secondary analysis of the 1971 Census for Jews living in Hackney concluded:

"The poor and aged, like many other inner city dwellers have a feeling that they are a forgotten people" ... "there still exists in the 1970's, a Jewish proletariat in the inner city whose needs must not be forgotten" (Kosmin and Grizzard, 1975, page 36).

The study highlighted the extent of isolation experienced by older members of the community, many of whom, it was suggested, relied upon the telephone as the main method of communication with their families.



Subsequent studies of suburban Jewish communities have highlighted gender as a significant differentiating influence upon the biographies of British Jews. A 1978 survey of nearly 2,000 Jews in the borough of Redbridge (Kosmin and Levy 1978) noted the 'male dominance' of religion as a recurring theme. The authors speculated "the loss of one's partner could be a reason for withdrawing from the practice of Judaism for Jewish women, given the strong family orientation of the religion" (page 11, 1978). Levels of observance at home were found to be lowest among single-person households, many of which comprised older widows.

A study of suburban Jews conducted in 1981 (Kosmin and Levy) noted the growing numbers of women participating in the work force. Of the economically active members of the community, women were far more likely to be working part-time (51% compared to 5.8% of men), and to be employed nearer to their home. The study also found that men were more likely to remain in education longer, and families invested more in boys' education. With regard to age, the study again highlighted the relative disadvantage of older members of the community.

In contrast to the widespread poverty experienced by the majority of London's Jews throughout the nineteenth century, the Jewish community has evolved into one of the richest ethnic groups in Britain, during the course of the twentieth century. Indeed, Alderman (1992) notes: "British Jewry is roughly 30% wealthier than the general population amongst which it dwells" (page 328, 1992).

The majority (70%) of Britain's Jews still reside in Greater London (Baker 1993), however, by the mid-1980's only one eighth of the community remained in the East End of London. Data from the 2001 Census indicates an on-going decline in the overall size of the population. The demography of the Jewish population differs considerably from the wider population, in a number of important respects. Alderman (1992) notes that significantly more Jewish men and women are concentrated in professional and managerial occupations as compared to the wider population. The Jewish population has



comparatively lower fertility rates and a higher life expectancy. Despite such changes, a postal survey of Jewish women (Schmool and Miller 1994) found that women retain primary responsibility for the home and family and single women report having 'no place' within the wider community.

The overall demographic picture of the Anglo-Jewish population is one of an expanding number of older members alongside a declining number of those who are economically active. It is estimated that the numbers of those aged 90 and over will increase by approximately 50% over the next ten years. For this reason, Valins (2002) has suggested that the Jewish population offers insights as to the future of an ageing wider population in the UK.

#### Anglo-Jewish Histories: Conclusion:

A brief review of existing historical accounts of Anglo-Jewry sets the stage for an ensuing discussion of lives in care and has highlighted a series of thematic concerns that shape the study as a whole.

It is clear that through time and across differing strata of the community, gender has patterned the lives and relations of Anglo-Jewry. The development of an infrastructure within the Anglo-Jewish community is characterised by exclusions along the lines of class and gender. Thus, various aspects of identity have been argued to interact within the context of communal institutions, differentiating members of the community not least in relation to status and leverage.

Through an attention to historical constructions of the Jewish community a number of prominent themes and organising categories have been noted. Unified notions of the family and community have obscured the divisions within them. Despite the limited attention given to gender at an explicit level, it is therefore embedded within narratives of the community. Normative constructions of femininity have over-shadowed the widely differing experiences and perspectives of Jewish women, whilst Jewish masculinities are



rarely delineated. It has been argued that gendered identities are constructed 'in place', an outcome of this being the absence of men in accounts of the private and of women from representations of the public sphere. Rarely is gender theorised in terms of fluidity and movement despite the marked geographical and social mobility of the community.

A public/private divide has provided the logic for a gendering of place and space, despite evidence to suggest considerable overlap between work and home and of the social and economic activities of women outside the home. A key outcome of the organising influence of this imposed divide has been an absence of attention to interactions and negotiations between men and women. The manner in which mobility has been experienced and achieved in gendered ways is similarly overlooked.

Constructions of the Jewish community according to a paradigm of consensus have been considered against a variety of socio-economic factors that divide and differentiate experiences of community membership. A meta-theme of 'Jewishness' in representations of the community therefore appears counter-productive to the endeavour of understanding the interactions of culture, class, gender and age.



## Policy and legislation

From charity to a welfare state:

The structure and organisation of charitable relief in England underwent significant change toward the end of the nineteenth century. The once prevalent belief that deprivation and hardship was rectifiable through promotion of a work ethic and principles of self-help, was laid open to question through a series of prominent accounts linking poverty to environmental and socio-economic factors. Charles Booth's 'The Life and Labour of the People of London' (published in parts between 1889-1903), Seebohm Rowntree's 'Poverty: A Study of Town Life' (1901) and Beatrice Webb's 'Minority Report of the Royal Commission on the Poor Laws' (1905-9) were instrumental in facilitating a shift in public attitudes. They served as the foundation to subsequent welfare legislation by the Liberal government of the time, including the Old Age Pensions Act (1908) and the National Insurance Act (1911).

However, from the outset, welfare legislation upheld social divisions and inequalities. Williams (1989, 1996) has drawn attention to the links between welfare provision and immigration control, arguing that gender and nationality shaped the inception of the Welfare State. The Aliens Act (1905) introduced powers to deny entry to those likely to make a claim on welfare support. At the same time, built into welfare provision was a distinct model of the family premised upon the position of men as breadwinners, with women as dependants.

"The introduction of some of the first forms of social welfare rights and provisions took place within a context where the boundaries of citizenship were becoming more circumscribed and its social geology in terms of differentiations around gender, 'race', age and disability, more complexly layered" (page 19, 1996).

A notable inconsistency characterising the construction of the Welfare State is that certain key principles organised the development of policy and legislation whilst remaining



poorly defined. Thus 'nation' exists in a largely negative form within much political discourse, defined according to the boundaries drawn by exclusionary immigration policy. At the same time, despite a central focus upon the family in welfare policy and legislation, the gender relations underpinning this construct rarely attracted explicit recognition or acknowledgement.

#### Gender and the Welfare State:

In the post-war period, characterised as an era of welfare consensus, the implementation of policy and legislation progressed according to a normative construction of the family. It has been argued that welfare provision promoted a white, middle class ideal of the family in which women were assumed to be both willing and able to remain at home and undertake the primary function of caring for their husband and children (Abbott and Wallace 1992). Pedersen (1993) has outlined the manner in which rights-based entitlements were distributed to men both for themselves and their wives and children whilst lesser means-tested benefits were provided to women only in the absence of men. The state thereby provided no structure of support to working women, especially those with children (Williams 1989).

Agarwal (2000) has noted the manner in which a unitary model of the household has underpinned both economic theory and policy development. Such an approach treats the family as a single entity, with common preferences and interests and assumes the presence of an altruistic head of household. Agarwal challenges this model on the basis that it ignores relations of power and fails to recognise self-interest and individual differences. Instead, it is argued that families are better understood relationally, according to a process of bargaining. The outcome of directing resources to (male) household heads effectively reduces the bargaining power of other (female) family members, thereby compounding inequalities.

Pateman (1989) has outlined the various levels at which the welfare state interacts with women's lives, highlighting its continued reliance upon the unpaid welfare labour of



women. Similarly, Williams (1989) has highlighted the welfare system's reliance upon both women and overseas workers. The poor rates of pay available to these workers serving to maintain lower social expenditure. From the outset, the welfare sector has been a major employer of women under conditions of rigid gender segregation of tasks and salaries (Hay 1996). Means and Smith (1998) have argued that the limited formal training given to care workers serves as an indication of the underlying assumption of the 'natural' caring abilities of a largely female workforce<sup>2</sup>.

A key feature of the socio-political debate upon welfare in the post-war era has been the 'ruling out' of certain issues and perspectives. Thus, Wilson (1980) has argued that economic and political forces combined 'to create a culture in which it was difficult to articulate or know about any oppression of women' (page 207, 1980). At the same time, a framing of social problems according to a concern with deprivation and poverty has subsumed the particular experiences of Black people and women. This being despite evidence indicating inequalities in access to, uptake and usage of the NHS, pensions, housing and education according to 'race' and gender (Hay 1996).

#### Ageing and the welfare state:

The National Assistance Act (1948) was designed to abolish and replace the existing Poor Law provision and was informed by a desire to move away from the Public Assistance Institutions (PAI) that had come under increased critical attention following the end of the war. Means and Smith (1998), highlight two key characteristics of care policy and legislation of this period. Firstly, institutionalisation remained the primary response to older people with care needs (the provision of community-based resources was given scant consideration). Secondly, "older people are conceptualised in nearly all policy documents as passive and dependent" (page 328, 1998).

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<sup>2</sup> For example, the Williams Report of 1967; 'Caring for People: Staffing Residential Homes' found that 80% of staff had no formal qualification for the work they were undertaking.



While the 1970's witnessed a growth in the number of homes specifically designed to accommodate 'elderly mentally infirm' (EMI) clients there was an absence of specific attention to the needs of people with dementia and other forms of cognitive impairment within policy and legislation. This absence has been highlighted as an on-going impediment to the care of people with dementia within contemporary services (Cantley 2001). While social services were given increased powers and duties to identify, assess and provide services for older people, this took place within a context of competing client groups and service priorities.

"Research studies confirmed that social services departments maintained client group hierarchies with elderly people at the bottom." (Means and Smith, 1994, page 25)

#### Welfare and the New Right:

Critiques of institutionalised care in the 1960's and 70's (Goffman, 1961, Foucault, 1971 and 1973 and Townsend 1962) served to highlight a concern with the depersonalising, regimented and disempowering nature of institutional life. However, a desire on the part of a 'New Right' government to limit the role of the state and to introduce a market economy to social care was a powerful influence upon both the speed of change and the manner in which it was structured. The White Paper, *Caring for People* (DoH 1989), while recommending a central role for social services departments as the 'enablers' of care provision, tied such a role to a 'mixed economy of care', giving emphasis to provision by the independent sector.

According to the ideology of the New Right, 'welfarism' was seen as a source of social dependency and a drain upon an enterprise culture. Within this context older people were viewed (and represented) as burdensome (Biggs 2001). The requirement upon local authorities to stimulate independent sector provision led to the closure of large numbers of residential care homes under their jurisdiction. A report by the Local Government Information Office 'A Woman's Place is in the Home?' (1990) noted:



"Any closure of local authority homes will affect women most as they provide the majority of services in them."... "The consequences for women providing services run on a contractual basis are likely to be less job security, lower wages and poorer conditions of service". (Page 1/2, 1990)

New Right constructions of the family held a key role in organising debates on policy, morality and welfare spending. Abbott and Wallace (1992) have argued that the rise of the New Right heralded the reinstatement of a patriarchal, self-reliant nuclear family as the norm. The erosion of family values was constructed as a linking concept between moral decay and economic decline, with the breakdown of the family linked to state dependence. As part of the promotion of an ideology of active individualism a notion of citizenship was introduced to constructions of welfare service users as consumers. Alongside constructions of the family, citizenship was presented in gender-neutral terms obscuring the gender bias inherent within welfare provision whilst progressing a 'gender-blind' debate upon needs, rights and entitlements (Lister 1997).

The shift away from institutionalised care within policy and legislation incorporated the repeated invocation of community as a vehicle for achieving this.

"As research has fully demonstrated it is not 'the community' which cares for dependent people but, in the majority of cases, it is women in family settings. The continued use of the term 'community care' masks the true responsibilities, burdens and costs of care". (Higgins, 1989, page 10)

Highlighting the gendered division of labour with regard to familial care has therefore been an important feature of the deconstruction of 'community' as upheld in policy and legislation. Alongside this, the manner in which gender interacts with both age (Arber and Ginn 1990) and class (Arber and Ginn 1992) has also been demonstrated to further structure inequalities in experiences of care. Despite a paucity of attention to minority groups and communities within community care legislation and policy, there is growing evidence to suggest that services are less accessible to Black and ethnic minority carers. Also, that much service and support provision to informal carers struggles to address the specific needs of ethnic minorities (Ahmad and Atkin, 1996, Gunaratnam, 1997, Patel, 1990).



Despite only limited attention to the needs and perspectives of informal carers in the NHS and Community Care Act (1990), subsequent legislation has been aimed specifically at carers and their right to an assessment of needs (Carers' Recognition and Services Act 1995, Carers and Disabled Children Act 2000). However, this recognition of carers may be understood as signalling a desire to maximise informal care input as a means of controlling public expenditure, with particular implications for women, given their predominance as carers.

Means et al (2002) have characterised 'New Labour' reforms as a move away from reliance upon market principles and competition to promote improvements to provision and toward a greater focus upon 'quality'. They cite a range of initiatives designed to monitor and appraise performance as an indicator of the expansion to the surveillance of services.

The Care Standards Act 2000 has introduced a range of national minimum standards for care across a number of services, including care homes for older people (DoH 2001). The standards explicitly signal a desire to maximise service users' personal autonomy and choice, highlighting the need to be both flexible and 'person-centred'. However, a backlash from within the independent sector has highlighted the lack of additional funding or resources through which to meet these minimum standards.

A return to charity:

Easterbrook (2003) has noted that the proposed changes are likely to reduce the profit margin of private sector homes, potentially leading to a greater need for individual residents to 'top-up' their fees. A study of voluntary sector care homes within the Jewish community (Valins 2002) has pointed to an increased dependence upon fundraising and charitable donations as a means of meeting the increasing short-fall between funding and the actual costs of care. A recent media campaign by Jewish Care (April 2003) has drawn attention to an annual deficit of £3 million.



The role of charities as providers of care, funded by the state and contractually regulated by local authorities has altered the identities of these organisations, influenced their relationships with service users and led to a strengthening of their position and range of powers. The 'commercialisation' of the charitable sector, has seen an expansion of many organisations into merchandising and solicitation of corporate support. Research into charitable giving has highlighted the manner in which the wider economic context (boom and recession) influences levels of giving and support for charities, at both an individual and a corporate level (Eayrs and Ellis 1990, Lloyd 1993). Despite this, charities are taking on increasing responsibility for areas previously considered the domain of the state with an attendant shift in the client groups targeted by them.

A significant 'knock-on' effect of this re-focussing of provision has been the erosion of 'preventative' services. It is estimated that 80% of older people who require help with domestic tasks now rely exclusively upon familial and informal support (Brodhurst and Glendinning 2001). Given the predominance of female family members as carers, such changes may be understood to have a particular impact upon women.

There is also growing evidence of the relationship between the market and the provision of welfare, with charities serving as intermediaries<sup>3</sup>. A study of 'corporate philanthropy' (Lloyd 1993) has highlighted the benefits to 'reputational assets' for national and international corporations through charitable giving. This relationship may be understood as an indirect influence upon the hierarchy of needs and perspectives supported by the voluntary sector.

"The voluntary sector's donors, individual and corporate, whether of money or of service, think and act quite differently. Implicitly they discriminate - between causes, between beneficiaries, between times and occasions" (Hodson, 1991, page 4)

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<sup>3</sup> Charities are linked to the stock market through the investment of reserves, with no guarantee that such investment is ethical. The media has recently reported the erosion of these reserves following a down-turn in the economy (Benjamin 2003).



The voluntary sector is by no means the dominant provider of residential and nursing home care, with private care providers accounting for a large share of the market<sup>4</sup>. There are a number of key differences in areas such as accountability, corporate strategy and ethos between voluntary sector and private sector providers (Cantley 2001). However, as part of the independent sector, charitable and community organisations are required to compete with these large national and multi-national corporations for local authority contracts. The replacement of core funding and grant assistance with a contract culture has heightened competition amongst providers and intensified the need for fundraising and solicitation of donations. An important outcome of this being the manner in which the need to fundraise structures the relationship between charities and service users and the wider public perception of those in receipt of support and assistance.

"It could be argued that the identification of people with disabilities through the use of (fundraising) posters actually establishes 'the disabled' as an out-group" (Eayrs and Ellis, 1990, page 349).

In order to promote sympathy or pity, as the underlying motivation for charitable giving, fundraising places emphasis upon disability and need. Such an emphasis may be understood as potentially undermining an 'awareness-raising' agenda that promotes social membership. An increasingly politicised disability movement has highlighted the emphasis upon a 'personal tragedy' model of disability as promoted by many charities. Oliver (1990, 1996) has criticised the 'tin-rattling' fundraising activities of many charities as promoting an image of disabled people as 'burdens of charity', pointing to the restrictions upon an explicitly politicised agenda associated with charitable status. "The appeal to the public on our behalf is still the same old appeal to pity, the begging bowl in modern form" (page 25, 1996).

Policy and Legislation: Conclusion:

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<sup>4</sup> By April 2000, for-profit companies provided 69% of long-term care placements of older people and people with physical disabilities in comparison to a 14% share by the voluntary sector (Player and Pollock 2001).



A brief account of the development of the Welfare State has highlighted the interactions of differing areas of policy and legislation. It has been argued that gender, 'race' and age are mediating factors in the provision of welfare. Exclusions and variations in provision according to these social categories have served to compound inequalities and maintain social hierarchies. Whilst patterning the provision of support gender issues are embedded within social policy, rarely attracting explicit recognition. Certain organising constructs within policy, including notions of community, the family and citizenship may be understood as both gender biased and gender blind. Thus, many of the key debates within social policy have been addressed and discussed in gender-neutral terms.

Despite notable shifts and changes to the activities and roles of charities and their relation to the State, this overview has highlighted the power of these institutions. Charities possess an authority, exercised not least through representations of those in receipt of their support. Such authority empowers charities to structure the relations between a variety of stakeholders and wider social attitudes to issues such as need, disability and poverty. Charity is itself, a selective and discriminating process and thereby stands in contrast to discourses framing the receipt of support and assistance as a universal right for those in need. Separate from the state, individual charities differ from one another in regard to their values and lines of accountability and this is tied to the often hidden and thereby less directly regulated influences upon their activities. Importantly, given their reliance upon support motivated by sympathy and pity their existence may be understood as precarious and vulnerable to a host of socio-economic factors.



## Organisational Representations

A study by Eayrs and Ellis (1990) of posters used by the mental health charity MENCAP, has highlighted the hierarchy of identities associated with representations of disabled people. The study confirmed existing research demonstrating that images of children were particularly effective in provoking public sympathy. It also noted that more favourable attitudes to charitable images were associated with women and higher educational level and socio-economic status, thereby highlighting class-based and gendered differences in responses to charity propaganda. Posters that sought to promote images of people with a mental handicap as 'valuable members of society' with the 'same rights as everyone else', were ranked lowest for their effectiveness in encouraging respondents to donate money. The posters that most directly elicited feelings of guilt and pity were ranked highest in terms of wanting to give money. The authors conclude: "In other words, people liked the posters which did not challenge their attitudes. This bodes ill for posters aimed at reducing the notion of 'differentness' of people with a mental handicap" (page 358, 1990).

On the assumption that this study demonstrated a 'general relationship between charity and disability', the methodology was repeated in relation to ten posters used by the Alzheimer's Society (Bender et al 2002). This subsequent study confirmed the finding that posters evoking guilt or pity were much more likely to prompt donations. "We are left with the finding that posters which make the clients objects of pity elicit money; but of course at the same time they support the negative stereotype and negative social valuation of those clients" (page 36, 2002).

Based upon the findings of these two studies it is possible to highlight a number of key issues with regard to charities supporting disabled people.

- Visual images have been shown to be a powerful tool in structuring (emotional) responses to disability.



- A tension exists between a charity's need to elicit donations and a concern to challenge stereotypes of disability.
- In the majority of cases the power to represent people with disabilities lies with the organisations providing services rather than with service users themselves.
- Images of disabled people are being made use of to elicit funds to support organisational aims and are tied to promoting a public presence for such organisations.
- A hierarchy of identities exists in respect to the effectiveness of images at generating funds (and the response of those targeted by these images).

During the period of the present study, Jewish Care 're-branded' its identity and launched what it described as a 'hard-hitting' communications campaign, featured mainly within the Jewish press. A report in the London Jewish News stated:

"A series of controversial press ads, based on the theme of values, will hold a mirror up to the community and undoubtedly force Anglo-Jewry to consider how it provides meaningful care and attention for members who may be struggling with certain personal or family issues". (LJN, 21 June 2002)

A number of fundraising images were used during the 'Jewish Values' campaign, representing what were reported to be real life situations referred to the charity. Jewish Care's Director of Marketing and Communications contributed an article to the London Jewish News to coincide with the launch of the campaign that highlighted research indicating the 'invisibility' of the charity - 'Jewish Care appeared to be the community's best kept secret'. The campaign was therefore designed with the explicit intention of fundraising.

Image 2 (Appendix 2) shows an older Jewish man sat eating dinner alone, with empty chairs to either side of him, juxtaposed with the text 'Jewish family'. The subject of the picture is distanced from the viewer by the dining table; he looks down at his dinner, thereby not engaging the gaze of the viewer. The small print begins 'no one should have to grow old alone'. As a comment upon the family within the Jewish community, this advert contrasts to Image 1, which highlights intergenerational ties. However, it clearly points to



the demographic changes highlighted by the present study, with social and geographic mobility attenuating familial links and levels of contact.

Image 3 (Appendix 3) shows an older man standing in a kitchen littered with 'post-it' notes identifying a variety of appliances and utensils. The image is juxtaposed with the text 'Jewish dignity', and the small print reads 'Alzheimer's disease can rob us of everything that makes us who we are'. Jewish Care's Director of Marketing and Communications states:

"The picture can't help but spell out danger, loneliness and vulnerability, while in its subtext it tells us of the loving but busy family who have tried to offer simple care solutions to a very complex, demanding and frightening illness." (Harris 2002)

Again, this image highlights the demographic changes within the community and clearly signals an absent family through the use of the post-it notes designed to orientate the subject. The subject looks down at the kettle he is holding, therefore again, not engaging the gaze of the viewer. The fact that he is pouring milk into his unplugged kettle heightens a sense that he is struggling to cope.

Both images carry an implicit message of an absence of familial support and therefore foreground the role of a supportive agency such as Jewish Care. The implied absence of a family may be understood to elicit feelings of guilt, within a community that places specific emphasis upon the importance of family. Both images tie representations of older people to dependency, loneliness and a lack of individual agency.

Fundraising advertisements are not, however, the only source of images of people with dementia. The private and corporate sector, also make use of such images to promote services and products. Image 4 (Appendix 4) is an example of advertising for a drug company promoting Exelon (rivastigmine), a drug that has been shown to slow the progression of Alzheimer's type dementia, for a time limited period, in some people. This image contains two women, both of whom engage the gaze of the viewer. In the



foreground is a younger female (relative?), behind her sits a dishevelled older woman, in odd shoes holding the stems of flowers that are scattered at her feet.

Comparing the three images draws attention to the gendered subtext of each. The use of women for the Exelon advert alludes to the predominance of women, both as carers and within the population of people with dementia. The text for the advert: 'If I wasn't crying so hard, I'd be laughing', signals the emotional labour of familial care. The foregrounding of the younger woman emphasises the benefits of the product to carers, who thereby appear to be the targets of the advert, rather than people with dementia.

In contrast to this use of female subjects, the Jewish Care adverts place men in a domestic environment as the subjects of their fundraising imagery. This despite the findings of the present study showing male service users to be in a minority across both residential and community-based services for older people provided by Jewish Care. One reading of the juxtaposition of the images with the values of 'Jewish family' and 'Jewish dignity' is that the implied loss of these values is underscored by images of men. They may also be read as heightening a sense of pity and a need for support through placing lone men in domestic settings. Finch (1989) has drawn attention to the gendered nature of familial obligations associated with providing informal care and support. As such, these adverts may be read as particularly targeting or tapping into feminine guilt regarding the unsupported male subjects and the absence of (female) family care.

All three adverts play upon an interaction of age, gender and dependency in order to promote their product or services, additionally the Jewish Care images explicitly include the interactions of ethnicity and cultural values (although the use of white subjects for the Exelon advert also suggests a target audience). While the Exelon advert may be understood as eliciting empathy for the younger woman alongside pity for the older woman, the Jewish Care adverts present their subjects as the objects of pity through the device of averting their gaze from that of the viewer, consequently heightening their objectification.



## Organisational Representations: Conclusion

The images of service users made use of by Jewish Care as part of the organisation's fundraising campaign point to the importance of control over representation and the manner in which this control serves particular aims and priorities. Organisational representations of service users contribute to wider constructions of the Jewish community and are structured by the interactions of factors such as age, gender, ethnicity and cultural values.

The manner in which Jewish Care constructs and presents an organisational profile offers an example of how discourses relating to identity are appropriated and interwoven in service to the organisation's promotional and fundraising activities. Fundraising images were found to carry a gendered subtext to enhance their efficacy and evoke a certain response from the targeted audience.

A consideration of the history of charity and philanthropy has served to enhance an understanding of Jewish Care's contemporary role, highlighting the various forces that shape its identity and activities. The status of Jewish Care as a charitable organisation has been explored within a context of the discourses that shape charitable activity, the influences upon it that stem from the requirement to generate an income and the outcomes of this upon the organisation's relationship to service users. Thus, organisational representations of service users - what is known of them and the nature of how they are known - are shaped by an over-arching concern to raise funds and attract donations.



## 5. LIVES IN CARE

Through an attempt to offer a cultural, historical and legal context to the present study, the social relations embedded within the provision of dementia care have been outlined. Certain themes integral to this study have therefore been traced across a wider context, offering an opportunity to consider relations in care as both connected with and upholding of these wider conditions. Of particular pertinence to the present study is what appears to be an active veiling of gender, in terms of both its influences and outcomes, in the development of the Welfare State and historical narratives of the Jewish community. Despite this, it has been argued that gender has an organising influence upon intra-community relations and more widely upon the very nature of societal membership.

Gender thereby shapes rights and entitlements but also interacts with a variety of factors leading to differences between men and between women. Not only is gender a crucial influence upon social experience and personal biographies, it is a vehicle through which integration into social hierarchies is achieved. This chapter will now turn to consider experiences of life in care. Themes already demonstrated to exist at a wider level will therefore now be considered within the particular context of institutionalised dementia care.

### The Care Regime

The following 'typical day' is based upon observation diary notes and analysis of video data generated for the residential care phase of the CPCEC project. It represents an amalgam of the common or representative features of the daily routine of eight units of five care homes that were studied as part of the project.

Morning:



7.30-8.0 The day begins with a handover from night staff to the first shift of day staff. During the handover discussion focuses upon who has had a waking night, who has been 'toileted' or has had an episode of incontinence. There appears to be limited association between information on those who have had disturbed sleep and the order in which people are assisted to get up and dressed in the morning. The process of preparing people for the day is begun by night staff and is ordered according to whether residents are classified as 'doubles' or 'singles'. Doubles are residents who require the assistance of two carers. Residents classed as 'singles' are often assisted to get up and dressed before the more physically dependent. Following the handover, staff are allocated residents for whom they will have the responsibility of assisting to get dressed and ready for the day.

During this period a skeleton staff is left to monitor residents. Many residents sit, asleep or dozing, in the day room area or at the dining tables awaiting their breakfast. There are no formal activities although a radio may be playing or a carer may switch on the television. The residents appear to have little input regarding the channel chosen on the television or radio, with popular music often playing.

On larger units residents may be offered an early morning cup of tea, however in smaller units the kitchen area is usually not open and on no units were residents witnessed being encouraged to help themselves to breakfast or to set the tables.

7.30-10.0 Breakfast is served. This usually consists of soft fruit, porridge, cereal, fruit cordial and tea or coffee. Most residents sit at a table for breakfast however, those who are immobile may be assisted to eat where they are sat in the day room area. Some residents classed as 'doubles' are assisted to eat their breakfast in their room rather than being brought to the dining area. They are then transferred directly to their seats in the day room area.



Following breakfast residents are assisted to use the toilet or, very infrequently, are prompted to use it. The process for this differs between units. On some units all residents are assisted to use the toilet at set times during the day, on other units toileting appears to be staggered. Very rarely are residents asked if they wish to use the toilet and offered a choice, the common practice is to inform residents that they are being taken to the toilet. In residential care units, where levels of self-care are higher, residents appear to have greater levels of autonomy regarding when they use the toilet.

During the breakfast period domestic staff use the opportunity to wipe down the chairs in the day room and/or vacuum the day room area. Occasionally a carpet cleaner may be used and dusting down of surfaces is carried out while most residents are either still in their rooms or in the dining area. After residents vacate their rooms for the day the domestic staff will then enter and clean them, changing bed linen, taking dirty laundry to be cleaned and emptying and cleaning commodes.

During this time the medication trolley is often present with residents being given medication before, during or after their breakfasts.

10.30-11.0 Morning tea and biscuits are served in the day room area. Tea is served to residents where they sit, again, residents are not encouraged to help themselves and carers decline offers of help from the more mobile residents.

On some units residents may be offered a choice of what they would like for lunch, however, this was more apparent in residential care than on nursing care units.



10.00

onwards

Formal activities occurred infrequently during the video data analysed. However, two sessions of activities, organised by a visiting activity coordinator or therapist, were recorded. These were drama therapy and a music therapy session, and each involved varying levels of participation by residents. The level of care staff involvement in these activity sessions was limited, with designated staff mainly running the sessions. Across all units there were few resources readily available for staff to initiate impromptu and less formal activities. On one unit a visiting male volunteer spent over an hour with residents engaging them in a group discussion and conducting various group activities and games with them. Few one-to-one activities were observed taking place and the only available resources for residents to engage with were the television or radio, and newspapers. At no time were care staff observed offering to read the papers for residents. Many residents were witnessed engaged in various forms of what appeared to be self-stimulation. This included wandering, repetitive folding, picking or grooming.

Late morning – afternoon:

11.45 - 1.0

Lunch. A choice of meals exists but residents are not necessarily offered a choice. This may reflect carer knowledge regarding preferences for individual residents. On some units lunch is served directly from the kitchen, while on others, food is served from a trolley after being wheeled up from a separate kitchen area. Some immobile residents may be fed slightly earlier than others, while in their seats in the day room. Most residents are escorted/transferred to the dining area. Residents are served while sat at the table. Lunch usually consists of three courses; soup, a main dish with vegetables and a pudding. Lunch is served with fruit cordial and/or water.



Some sweeping up of the day room may take place during the lunch period.

Following lunch, residents are assisted to use the toilet.

During this period (11am-3pm) the main sources of entertainment are the television, the radio, tapes and newspapers. However, there are few resources made directly available to residents to occupy themselves, neither are they introduced by staff, despite an evident lack of stimulation. Self-stimulating behaviour continues including vocal repetitiveness, wandering and self-grooming. A number of women, across all the units visited were observed engaged in a variety of 'domestic chores', such as a repetitive wiping of surfaces and folding and unfolding of tissues, tablecloths, clothing and blankets.

Carers appear less busy in the period following lunch and may use this time to write up care plans. On one occasion a hand massage was offered to each resident in turn and this represented the only carer initiated one-to-one activity occurring throughout the video data analysed. On one unit residents were invited to a meeting to express views on food and other services provided within the home.

In the period following lunch some relatives arrive, spending varying amounts of time with individual residents. The number of visiting relatives appeared limited. Only one project participant received a visit throughout the videotape analysed. However, filming ended at 7.00pm and at 1pm on Fridays and there was no filming at weekends.

2.00

Care staff for the second day shift arrive. There is an overlapping period with the early day shift that is used for providing a handover for the newly arriving staff and for the earlier shift to write up care plans.



Late afternoon - early evening:

3.00-3.30 Care plans are written up and the early day shift comes to an end and staff leave. The daily entries in the care report tend to focus upon certain aspects of behaviour and levels of well/ill-being. Generally, entries tend to be one or two lines in length with limited cross-referencing to the care plan. The entries themselves may be two or three days apart. Representative examples of daily report comments included:

- "X is comfortable, contented in herself. Assisted with toileting."
- "Comfortable day, meals taken well. Socialising with staff and residents at mealtimes."
- "X in a pleasant mood as usual, eating well, personal care given".

Throughout the late afternoon and early evening period there are low levels of activity taking place on either a formal or informal basis. Carers maintain a presence within the day room areas, especially on the nursing care units, in order to monitor residents. Much of this monitoring takes place silently and/or with carers talking amongst themselves to the exclusion of residents. Toileting takes place before and after supper. Some residents may ask to use the toilet and be told they have to wait their turn or that they will be taken later, this is especially the case during busy periods.

3.15-3.45 Afternoon tea served with biscuits or cake.

3.00-4.00 Cleaning - wiping down of seats and floor sweeping.

5.15-6.15 Supper. A light meal, served with fruit cordial and/or tea.



Before, during and after tea the medication trolley is present on the units.

The main sources of entertainment and stimulation are from the television, radio, and from tapes. Most tapes appear to be targeted for residents whereas television programmes and radio channels often seem to reflect the choices of staff rather than residents. Throughout a large portion of the fieldwork, either a television or radio was on - but on no occasion were residents consulted as to what was being played/shown. Without the sound of the television or radio there would be long periods of almost complete silence on the units.

6.30-9.30      Following supper, residents return to the day rooms. In larger homes some residents may move or be transferred to smaller day lounges upstairs. Each carer is allocated a number of residents whom they assist to get ready for bed. Levels of choice over bedtime vary. The more independent residents exercise greater levels of choice over the time that they go to bed. Those who are wheelchair-bound tend to be taken when a carer is available. Some residents may ask to go up to bed but are required to wait their turn. The day shift carers begin the process of assisting residents to bed. A handover then takes place when night staff arrive at 9.30pm and night staff then take over in assisting residents to bed.

Care home documentation:

One component of the triangulated methodology of the CPCEC project was the study of documents and written records kept for each resident. Upkeep of this paperwork was observed during fieldwork to be a regular feature of the role of care-workers and other related staff within each home. An account of this paperwork is offered here in order to give an impression of how such documentation both structures and regulates the provision of care and wider relations within the care home environment.



Each resident within a Jewish Care home has a care plan in addition to the day-to-day reports that are written about him or her. These care plans may differ in length and detail from one home to another and from one resident to another. This relates to factors such as the input of differing social workers, existing paperwork that a resident arrives with and the level of information about an individual that is readily available. However, throughout Jewish Care facilities a standardised set of paperwork forms the basis of the care plan for each resident. In addition to medical and physical care information, a resident's care needs are assessed upon arrival and this is reviewed twice a year. The amount of social history held upon each resident was found to vary considerably, often being of a far more detailed nature if they had attended day care prior to admission. The care plan itself contains a number of sub-headings which pertain to the social needs of the resident and a 'problem' - 'interventions' - 'goals/expected outcome' format which forms the basis for the individualised care plan for the proceeding months. Additional sub-headings such as 'factors to maximise contentment' were found in some files.

Some typical entries from the care plans for residents in the sample included:

'Problem - 'Dementia'. Goal - 'to maintain contact with reality'. Intervention - 'to remind constantly of time and space. Spend time with X to guide her to groups. To help set out tables, to enjoy music and movement, constantly reassure, to divert emotions when distressed, to enjoy support from family'.

Problem: Altered thought process related to dementia.

Goal: To maintain effective communication skills. X to maintain interpersonal interactions with others through individual and group activities.

Interventions: Allow to convey her needs and wants even though this is often a struggle. Validate specific feelings - anger, fear and happiness. Encourage X to be with others that will be supportive and give meaning to present day existence. Promote self-esteem, orientation and memory recall.



**Problem:** Need to socialise due to disorientation of time and place.

**Goal:** To be aware of surroundings. To demonstrate trust in caregivers and accept caring. To feel safe in her environment.

**Interventions:** Spend time with X, as much as possible one to one. Address by her name, give her a smile. Ensure all explanations for any procedures before attempting them.

Avoid vague or evasive remarks.

Significantly, given the challenge of eliciting and accurately interpreting the views and perspectives of some residents with dementia, the care plan provides an important source of reference to visiting professionals, family and management figures, in their assessment of the care on offer to an individual resident. The care plan constitutes the main source of care information alongside accounts from keyworkers.

A standardised set of paperwork (Standex) has been introduced by Jewish Care and is intended for use throughout all the residential and nursing care homes. The Standex contains 13 main sections by which the written input on each resident is structured and shaped. The care plan is usually completed by the keyworker while the care worker allocated to the resident on each shift completes the daily reports.

The 13 headings show a clear emphasis upon physical care. Each aspect of care is broken down into a set of tasks with a requirement that their completion is recorded within the file. These tasks are then repeated or updated at intervals set by the paperwork or the pre-set criteria for completing the paperwork, i.e. daily report, short term and long term care plans. The social care<sup>5</sup> of the individual resident is contained within the overall structure of the Standex and therefore addressed through the completion of discrete tasks, which are then noted on the different forms. The day-to-day report is held separately from the care plan, the use of which was more limited. According to carer interview responses, access to the care plan file is dictated by the amount of time available on a given shift.



Within the short term care plans social care was 'operationalised' into tasks and activities. However, it was by no means always the case that socially-oriented needs or tasks would be contained in this section. In the long-term need assessment and care plan section the depth and amount of information recorded varied, with sections sometimes left blank or with only one or two lines of comments. Within the social activity section, which contained a pre-determined range of activities, a gender bias was apparent in those activities on offer. While a number of options were gender-neutral, activities such as bingo, cookery, hairdresser, knitting, manicure and needlework could all be viewed as more likely (though certainly not exclusively so) to appeal to older women than to older men. A range of correspondingly 'masculine pursuits' were largely absent from this list.

A number of issues arise from an examination of the structure and organisation of this textual information.

- The utility and value of records of previous assessments and contact with an individual, either short or long-term, was based upon their 'fit' with the standardised paperwork, (i.e. the personal and social information gathered during attendance at special day care was only relevant in terms of how it was operationalised into specific tasks and activities).
- The social representation of the individual in files is decontextualised from the time, place and social relations associated with the gathering of information.
- A medicalised discourse and associated practices are privileged by the lay-out, headings and organisation of information and the subsequent care requirements that it dictates.
- Only those aspects of an individual's history and identity that are recorded within the paperwork are explicitly addressed during care in a structured or systematic fashion.

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<sup>5</sup> Social care refers to those aspects of support that attend to the identities of residents, seek to support a sense of self, offer an opportunity for residents to express themselves and show a concern for the 'inner world' of residents.



Subsumed within a task-based regime, social support and socially-oriented care seems to have been incorporated into an already established care regime. Care homes thereby appear to treat social care as an 'add-on' to the existing physical care routine. Throughout Jewish Care the 'Standex' paperwork, which is used to standardise the way in which information is kept and recorded on individual residents, offers an illustration of how this has occurred. The 'problem' - 'goal' - 'intervention' format, effectively highlights discrete aspects of a residents identity and caters for them through the completion of specified tasks. The attributes upon which the files focus, are largely those deemed problematic, with little apparent concern shown to support more positive aspects of identity.

Care and support is therefore structured according to specified, time-limited tasks and such a format highlights fragments or components of identity. Golander and Raz (1996) have argued that highlighting certain social 'problems' or needs within a care regime runs the risk that these features may act as the 'leitmotiv' for an individual's wider identity. At the same time those wider, over-arching but arguably more abstract aspects of identity, perhaps more difficult to operationalise within a task-based format, are effectively sidelined. Thus, gender is rarely explicitly addressed within care plans despite imbuing biographies and social experiences.

## **Hierarchies in Care**

### Gender distribution

Gender has been shown to be a key factor shaping and differentiating the experiences of older people in the UK. By the age of 89 years it is estimated that there are three women to every man, with the greatest differences in the proportion of men to women amongst the very old. On average women live five years longer than men and have higher levels of morbidity and health service use than men, and 54% of women aged 70 years and over live alone compared to only 24% of men of the same age group (Hayes and Prior 2003). A recent study of the provision of care and use of services found 600,000 people over 65 years receive non-residential services from local authorities, 400,000 are resident in long



stay care, and a further 34,000 in hospital. Of the population in residential or nursing home care, 70% are women over the age of 74 years, roughly half being over 85 years (Richards 2001). Despite this marked gender imbalance there is a dearth of research and attention to this aspect of the demography of care and its implications for experiences of care settings.

Jewish Care currently owns and runs twelve residential facilities for older people. Of these facilities nine are registered as residential care, one as nursing care and two are dual registered. Within these homes there are four dementia care units, two in residential care and two registered as nursing care. Dementia care units are distinguished by having a higher ratio of care staff to residents, with staff reported to have a higher level of training with regard to dementia. Specialist (nursing) dementia care units are also notable as being a more expensive form of care; gate-keeping professionals placing clients in specialist units are required to apply for additional funding, over and above the ceiling limits set by local authorities for nursing care.

Of the overall population of 750 people residing in Jewish Care residential facilities there is a gender distribution of 78 % (588) women and 22% (162) men. Breaking this down according to the differing types of care there is a distribution within residential care of 81% women and 19% men, a ratio of one man to every 4.3 women. In nursing care the proportion of men is greater, with 74% women and 26% men, a ratio of one man to every 2.9 women. The largest proportion of men exists in dementia care units, with 70% women and 30 % men, a ratio of one man to every 2.3 women.

At the outset of the CPCEC project, Jewish Care supplied the initials, gender and dates of birth for all residents within their facilities who were known to have a formal diagnosis of Alzheimer's type dementia. In all, 95 residents were identified across the twelve homes, representing a proportion of 13% of the overall care home population. These figures did not include people affected by other forms of dementia however, Alzheimer's is known to



be the most common form of dementia, accounting for between 50-60% of all cases<sup>6</sup> (McKeith and Fairbairn 2001).

Of the 95 people identified by Jewish Care as having a formal diagnosis of Alzheimer's type dementia, 82% were women and 18% men, representing a ratio of one man to every 4.5 women. When considering the comparatively high ratio of men to women in special dementia care units (1:2.3), it appears that gender is an important variable in relation to the type of care received by people with dementia. Men appear to be in receipt of a disproportionately large share of specialised dementia care (the most expensive form of care available), there are a number of possible explanations for this.

Research into the community-based care of people with dementia has demonstrated that the presence of support from a relative serves to sustain people in the community for longer than those who live alone (Bergmann et al, 1978). Given that women tend to live longer than men and to marry men older than themselves, there is a likelihood that a higher proportion of men with dementia will have a resident carer. Research into gender and ageing has also highlighted a marked financial inequality between men and women (Arber and Ginn 1990). As such, men are financially better placed to afford private care and support at home. These findings suggest the possibility that men with dementia are enabled to reside in the community for longer, as such the severity of their dementia may be greater at the point of admission, requiring higher levels of care. At the same time, social factors such as an absence of a resident carer and lower levels of financial and other resources may lead to women being admitted to care earlier, hence the high ratio of women to men in residential care.

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<sup>6</sup> This would suggest, at most, a third of the population of Jewish Care homes have some form of (formally diagnosed) dementia. It is interesting to set these figures against national statistics regarding the dependency characteristics of individuals admitted to residential and nursing care. Matheson and Summerfield (1999) reported that 54% of people in residential care and 38% in nursing care had mild confusion, while 25% in residential care and 46% in nursing care were admitted with severe levels of cognitive impairment. Thus, nationally, 79% of residents in residential care and 82% in nursing care have some level of confusion. The low numbers, within the present study holding a formal diagnosis of Alzheimer's suggest that the condition remains (formally) undiagnosed for many residents.



Another possible factor influencing the high numbers of men in special dementia care may be a 'response bias' of gate-keeping professionals making placements. Research investigating community-based service provision has highlighted differences in the levels and types of care offered to male and female carers. Bebbington and Davies (1983) found that older women were less likely to receive support than older men, when caring for disabled spouses. Charlesworth et al (1984) found that male carers were more likely to receive both formal and informal support and this was often provided at an earlier point in the caring relationship. Bywaters and Harris (1998) revealed differences in the type of services provided, with older men more likely to receive home care assistance, especially cooking, cleaning and laundry. The authors recognised the possibility that male and female clients may request different types of support; also that relatives and other professionals may 'push' for greater assistance for male carers. Service providers may also respond to gendered differences in 'expressed need'. To date, no investigation has attempted to track placements of men and women with dementia according to the types of residential care that they are assessed as eligible for, or potentially gendered differences in the timing of requests for support by carers.

A further explanation for the disproportionately high number of men in specialist dementia care units is the possibility of gendered differences in the response to and experience of dementia. Existing research has reported an association between male gender and aggressive behaviour in people with dementia<sup>7</sup> (Eustace et al 2001, McMin and Hinton 2000, Lyketsos et al 1999, Ott et al 1996, 2000). Such findings suggest that men's conduct may present a management challenge in care settings requiring higher levels of staffing and supervision.

Variance in the distribution of men and women throughout residential care suggests that gender is an influential variable upon the pathway into care for many people with dementia. The apparent concentration of men in special dementia care units, with their higher ratios of staff to residents and higher costs to local authorities funding such

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<sup>7</sup> The overall absence of non-medicalised attention to gender and dementia has limited the potential for a wider debate on possible differences in how men and women cope with and experience dementia.



placements, could be viewed as privileging men. However, whether this concentration is viewed as an inequitable allocation of resources remains open to question. If men are generally admitted to care at a later stage in the progression of dementia, thereby requiring higher levels of care, then the gender distribution within the different sectors of care appears to reflect this. If however, men are understood as responding differently to the experience of dementia, presenting with higher levels of aggression and abusive behaviour, an alternative reading of their concentration in special dementia care is that these units function as depositories for clients presenting a management problem for a care home. From such a perspective there exists the corresponding potential that women may be overlooked, as a result of presenting less of a challenge. However, it is clear that gender serves to differentiate the provision and experience of care for people with dementia, highlighting the likely benefits of further attention to the causes behind such differences in provision.

#### Identity, status and context: The function of 'family'

Placing relations within Jewish Care in a wider cultural and historical context has offered an opportunity to trace the connections across time and place of certain constructions of the family and an associated ideology. Prevailing discourses on familial and community relations therefore appear to have an organising influence with identifiable outcomes for life in care.

The family and familial relations has been made extensive use of by Jewish Care as it constructs a corporate identity and presents itself to both service users and the wider Jewish community. Prior to the recent re-branding of the organisations identity, the slogan "Jewish Care: one big family", was carried on all organisational literature. The organisation also refers to the various smaller organisations and agencies that it has expanded to incorporate as 'the family of Jewish Care'. A host of fundraising adverts for the charity also make use of images of older and younger people embracing one another, highlighting the links between family relations and the role of the charity. A recent advert



for Jewish Care in the Jewish Chronicle (image 5/appendix 5) depicts an older and younger woman smiling at one another with their heads touching, accompanied by the text

"Imagine no more Jewish Care ... There would be no-one to turn to in your hour of need. No-one to care for you when you're at your most vulnerable. No sense of belonging and no traditions. Whatever care you got, it would be not be Jewish care."

The advert invokes an image of Jewish Care as an extension of the family and points to the role of the family as maintaining a sense of identity and cultural belonging. It highlights the extent to which family values structure the relations of the organisation to service users also, of how this relationship is based upon a shared cultural identity. As previously noted, such representations highlight unity and commonality, overriding any consideration of the divisions and differences that exist within the Jewish community and more locally, within Jewish Care.

In common with many care organisations, Jewish Care has fashioned itself as an extension to familial relations, thereby suggesting continuity between familial care and support and the input and services that it offers. To date, scant consideration has been given to how such a familial identity structures the relationship of workers to an employing care organisation. The extent to which 'false-kin' relations (Gregson and Lowe 1994) obscure carers' status as workers clearly has important implications for employment relations. Family care-givers have few rights or opportunities to collectively agitate for improvements to their working conditions and remuneration for their labour. The bonds and obligations that have been argued to structure familial care function to underpin commitment and limit resistance by informal care-givers. An emphasis upon familial bonds in a workplace context suggests a non-coercive form of control of workers, whereby a wider association of femininity to care is appropriated for organisational ends.

With regard to a hierarchy of gendered identities, Connell (1987, 1995) suggests that certain benefits and constraints are associated with differing types of masculinity. It is argued that a hegemonic masculinity emerges through a process of subordination of other



perspectives. Institutions serve as an important shaping influence upon these emerging masculinities through their authorisation of particular perspectives and the values they espouse. The notion of hegemonic masculinity highlights the manner in which institutions structure relations, providing a context in which certain perspectives are privileged. The values of a particular environment serve to structure differing forms of identification, simultaneously creating situations of advantage and disadvantage, in a manner that bisects both individual identity and collective networks of association and commonality.

As previously noted, studies of the Anglo-Jewish community have highlighted the central position of certain constructions of the family, with differing expectations of men and women underpinning familial relations. Baker (1993) has highlighted the importance placed upon marriage and motherhood for Jewish women and the implications for those who do not occupy such positions, arguing that the community is 'normatively family-based'.

"It is the festive meals, above all, which emphasise the family-based aspect of Judaism and the woman's role in maintaining this.' ... 'The unmarried or childless woman, the separated, divorced or widowed, unless she is part of an aware and caring community, will frequently feel excluded from this most central aspect of any festival". (Page 140, 1993)

Existing studies have highlighted a sense of marginalisation for unmarried women born out of an association between cultural practices and prescribed roles for women as mothers (Baker 1993, Schmool and Miller 1994). Similarly, studies of the suburban Jewish population in Greater London (Kosmin and Levy, 1978, 1981) have revealed a negative association between levels of religious observance and synagogue attendance and single, divorced or widowed status, for women. It therefore seems that the bases for community membership and inclusion generate a hierarchy of gendered identities.

Such findings draw attention to the manner in which status, especially for women, is tied to the family and their position as mothers and wives, signalling the interplay of discursive constructions of gender with lived experience. To be single, widowed or divorced serves to distance some Jewish women from the activities associated with religious observance



and leads to differing treatment from and relations with the wider community. Differences therefore exist between women according to factors such as marital status and motherhood, further indicating the importance of an attention to hierarchy within the Jewish community. Interestingly, there is a silence with regard to the status of single Jewish men within the community and of what this may indicate with regard to the differing pressures upon single men and women.

'The best decision I ever made was: 'not getting married'

(Entry for RH7 in 'Getting to Know Me' assessment form).

Interviews with care workers in Jewish Care residential facilities have signalled their perception that the centrality of the family is maintained at an interactional level. Care workers were asked to give an account of the topics of conversation covered in their communication with residents. 'Family' was the second most common topic, cited by 18 (56%) interviewees.

"The main things we talk about with residents is their past, like 'where were you working?' About their family or 'how many children have you got?' 'Oh, where are they?' 'How many grandchildren?' Something like that" (rhkc12(f))

Such reported interactions represent a positive aspect of carer/caree relations, creating opportunities for residents to discuss biographies and shifting the focus of communication away from an attention to the provision of care. However, some interview responses by care workers signalled an assumption of the existence of a family.

"Sometimes if you ask 'how many children have you got?' and she (doesn't) have any and you can see that maybe she is depressed and thinking 'why didn't I have children.' So you just have to stop because you don't want to go and hurt about it, because she's feeling low." (rhkc12(f))

Within the CPCEC project at least two (12%) of the randomly selected residents were found to have never married or had children. It is therefore pertinent to consider what



implications this attention to the family, and familial relations, holds for residents without families and those with little or no contact with their families.

Whilst containing limited information on the biographies of individual residents, most files were found to contain information on the families of residents. Whilst, for some, this was limited to the contact details of next-of-kin, other files offered the names of spouses, children, and occasionally of grandchildren. Care plans also sought to incorporate the views of relatives in the reviews of care, despite frequently failing to incorporate the views of resident themselves. A typical entry in assessment and review documents was:

"Comments of clients - 'Mrs X was unable to express a view. Her husband has no complaints.'"

However, there appeared to be no mechanisms in place by which independent advocacy was available to residents without families, when consulted upon their views of the quality and provision of care. It remains poorly understood how the unofficial advocacy of family members influences the provision of care or what this implies for residents who do not benefit from such advocacy. It may be argued that such differences in status are of particular significance for residents with dementia who may themselves be offered few opportunities to make a direct contribution to care planning.

The family-oriented environment of Jewish Care may be understood as a reflection of the centrality of the family within the wider Anglo-Jewish community. However, factors such as marital status and parenthood differentiate the experiences of individual residents. The promotion and continuation of ties and associations between a Jewish identity and the family signal a hegemonic standpoint within residential care demonstrating how normative constructions of the family thereby have concrete outcomes for life in care.

### Hierarchy and sexuality

The notion of hegemony has also been made use of to describe the process by which social status is acquired through the dominance and naturalisation of heterosexuality.



Butler (1990, 1993) has argued that heterosexist norms are supported through conditions of 'compulsory heterosexuality' within a variety of social settings. Butler highlights an association between hegemonic constructions of gender and heterosexual identity.

"Gender norms operate by requiring the embodiment of certain ideals of femininity and masculinity, ones that are almost always related to the idealization of the heterosexual bond". (Page 231/1, 1993)

Normative constructions of the family may be understood as an example of the articulation of such heterosexual bonds and a site for the reiteration of norms of gender and sexuality. Abel (1990) has argued that much community care policy relies upon such a normative model of familial relations at the expense of those who fall outside such networks:

"By emphasising familial obligations, policymakers accord a privileged place to those older people who obtain services from kin. The needs of the elderly who have survived all their relatives, whose children are estranged, who remained childless or who have lived their lives outside families are slighted." (Page 85, 1990)

A study by Hubbard & Rossington (1995) has highlighted the lack of attention to the perspectives of older lesbians and gay men, within housing and social care. The study found that many housing associations and local authorities held no information on the numbers of gay or lesbian service users and had made no attempts to investigate the quality of life for gay or lesbian clients. Interviews with older gay service users revealed experiences of homophobia within group-living situations. The study argued that many residential care homes were heterosexist in their promotion of services on offer, the emphasis upon family in care home brochures and corporate literature was one example of this, with many homes making reference to operating according to 'family values'. The study argued:

"Many lesbians and gay men do not have children or grandchildren. A culture that is based on judging someone's worth by success in procreation increasing every time another grandchild arrives, can be culturally alienating to many and perhaps particularly to older lesbians and gay men." (Page 45, 1995)



Many gay and lesbian service users were found by the study to have few opportunities to be open with regard to their sexuality, often for fear of a negative response from staff and fellow service users and few respondents reported friendships or contact with other gay men or lesbians. Gay residents in care homes indicated a sense of social isolation and an overall reluctance to be open about their sexuality.

For the present study, an important feature noted of the admission assessments carried out for new residents was that files showed little evidence to suggest that documented details of the lives of residents were added to as new information was obtained. The initial assessment literature thereby carried a central influence over what was known about a resident and how an individual was known to the care home and wider organisation. It is therefore important to consider what information such assessments commonly failed to elicit and how this may influence the experience of care. While some files offered information regarding the family of individual residents, at no time was the sexual orientation of residents explicitly touched upon in assessments or subsequent care planning.

The only occasion on which the sexuality of residents was made reference to within organisational documentation was when it presented problems, thereby highlighting the role of the care worker as regulator and monitor of residents' sexuality. Much sexualised conduct was also represented as symptomatic of dementia. The possibility that sexuality may be understood as a positive aspect of identity, relevant to the provision of person-centred care or the maintenance of biographical continuity, was not given attention within documentation. Without explicit attention to the sexual orientation of residents it may be argued there is an implicit heterocentricity underpinning organisational perspectives upon sexuality.

During interviewing for the CPCEC project, carers were asked in what ways residents expressed themselves sexually and how they responded to this. Only one interviewee, out



of 27, made reference to homosexuality, suggesting that, overall, there is an assumption of heterosexuality in the perception that care workers have of residents.

"There's a lady, it's kind of understood that she prefers ladies to men and has actually been touching some women inappropriately. That brings it's own bunch of hang-ups because that's somehow harder to deal with than a heterosexual. We have no one as far as I'm aware in a relationship of that sort, with two women or two men, but we found that with the lady who is touching up the females, staff were quite up in arms about it. They thought it was either, funny and laughed uproariously about it, or thought it was awful. And the lady in question is not someone you can ask, you couldn't say to her, because we all know that lesbians only came to be in the last ten years, I mean they didn't exist before that. She's um, you couldn't ask her outright. But again, the same principle applies, if she is behaving towards another client who doesn't seem to have a problem with that, but if it's a demented client, or someone who has no insight into what's happening, or is stressed by what's happening, then again you would apply the same principles to a heterosexual relationship". (Care home manager)

The possibility of knowing of the existence within care homes of homosexual and non-heterosexual residents is hampered by a lack of explicit attention to sexual orientation, which renders the homosexual population within residential care largely invisible. The 'up in arms' response of care workers, as perceived by this care home manager, suggests a lack of understanding and acceptance of differing sexualities. The assumed homosexuality of this resident is presented as potentially threatening and transgressive, in a manner usually applied to masculine sexual expression<sup>8</sup>. Another issue raised by this respondent is the perceived difficulty associated with how to address sexual orientation compounded by the view that the language for speaking about homosexuality may not be appropriate for older people. However, by overlooking the possibility of differing sexualities, care homes arguably generate and support conditions of compulsory heterosexuality.

Following admission to institutional care, there are many reasons why non-heterosexual residents may feel compelled to veil their sexuality. Historically, the 'medico-moral alliance' (Mort 1987) through which homosexuality has been criminalised, pathologised and presented as morally corrupt is likely to have had an important bearing upon the ways

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<sup>8</sup> The influence of gender upon the meanings attached to sexual expression will be discussed in greater detail later in this study.



in which many individuals have negotiated the presentation of their sexuality, throughout their lives. Additionally, the anticipation and experience of homophobic and stigmatising responses from both staff and fellow residents have been shown to be an important influence (Hubbard and Rossington 1995). However, it does not follow that sexuality and sexual identity is any less central to the lives, relationships or sense of self for members of this largely hidden population.

Any decision taken at an individual level, not to be open regarding sexual orientation must be understood as distinct from the processes by which care settings draw a veil over the sexualities of residents. There is a need for residents, and their visiting partners and friends, to know that it is safe and deemed acceptable to be open regarding their identity and relationships (Ward 2000). As such, there is a pressing need for the full spectrum of sexualities to be taken into account and offered the freedom of expression within care for older people.

### Lives in Care: Conclusion

With regard to the lives of residents in care the finding that social identity is poorly supported or attended to in the day-to-day provision of care, highlights the continued prioritisation of medicalised concerns. However, in seeking to provide 'Jewish' care, Jewish Care may be understood as making efforts to support the cultural identity of clients. A concern of the present study is the manner in which this support may be seen as partial, shaped by the values of the organisation and beliefs of individual providers of care. Of particular note is the question raised of whether a variety of perspectives are successfully supported and attended to, or whether normative conditions prevail, imposed upon a diverse population through an emphasis upon commonality and downplaying of difference. An exploration of references to and representations of family, sexuality and an associated hegemonic standpoint may be argued to suggest the latter.

Emerging from this analysis is a hierarchy of identities within care facilities, with factors such as gender and sexuality having an important influence upon the positioning of



individual residents and their relationship with the wider organisation. There appears to be a variety of ways in which a construct of the family functions within care settings. It has been argued that an orientation to the family orders identities in care, supporting a hegemonic status whilst overlooking the perspectives and interests of minority groups. Thus, certain versions of femininity and masculinity appear better accounted for and catered to, than others. The heterosexual form of an organisationally authorised notion of the family underpins a culture of compulsory heterosexuality in care, whereby non-heterosexual identities are treated as transgressive and problematic. It may also be argued that differing aspects of an individual's identity are themselves hierarchised, with a consequently partial attention to the identity of residents, as a result of disparities in how differing aspects of identity are taken into account.



## 6. HIERARCHIES OF IDENTITY - PART TWO

### Typologies of care

In order to fully interrogate caring relations there is a requirement to consider how the discursive construction of care shapes the way it has been understood and debated.

According to a feminist critique of social policy, the interconnected nature of care across a variety of settings and domains has been highlighted. This has led to proposals that a unified or generic model of care best underscores the gender inequalities associated with this form of social activity, irrespective of the settings and domains that provide a context for its undertaking (Ungerson 1990). This chapter will give consideration to the outcomes of such a perspective and its implications for an understanding of the widely differing forms of care.

A dichotomy of 'formal' and 'informal' care is in common usage within representations of care. This labelling of care offers little insight into the variety of relationships and situations that are grouped by such a dichotomy and reveals little of whose interests are served by such an ordering. Over time, 'informal' care has become a byword for familial caring and there has been little concern shown to further delineate the alternative forms of care that such a label may well connote. Similarly, the label of 'formal' care seems to indicate care work that is financially remunerated. However, such a category encompasses a diversity of caring arrangements and obscures important differences. For example there are occasions when unpaid care is offered in formal care situations also, when non-financial forms of exchange and reciprocity underpin care.

Embedded within the debate on care are the interests and political concerns associated with particular standpoints. As such, it is important to question common constructions of care and to consider the limits they set upon a discussion of care when undertaking a study such as this. Firstly, it seems pertinent to consider the implications of the term 'care' itself.



Shakespeare (2000) has argued that the term 'help' may better indicate the experiences and perspectives of those in receipt of support:

"'Care' is a word which is value-laden, contested and confused, particularly in the way it combines an emotional component and a description of basic human services. There is argument as to when it is necessary, what it means and how it should be applied" (p. IX, 2000).

It may also be argued that a certain political agenda woven into an unfolding debate on care has shaped the uneven attention that is given to differing forms of care, and the experiences and perspectives that have consequently been given prominence.

Arguably, the most socially prevalent form of care - the first to be learned, and the last to be surrendered - is care of the self. Yet, this form of caring has received scant consideration in attempts to conceptualise care. By contrast, self-care is a prominent theme within the media and consumer culture. As such, it is influenced by marketing strategies, which are targeted, frequently on a gendered basis, to groupings of consumers. Consumer culture sets norms and ideals against which an individual's sense of self is measured. A relationship with the self is therefore mediated by discourses of consumption, with evaluations of the body defined at a wider, social level.

Care of the self is also a particular concern within medicine. A breakdown in self-care is frequently pathologised and, in the case of older people, 'self-neglect' may trigger institutionalisation. Entry to institutional care often leads to the (partial) relinquishment of self-care and its boundaries come under negotiation. As research investigating structured dependency and over-accommodation has demonstrated (Wahl 1991), care regimes may encroach inappropriately on the practice of self-care, usurping responsibility and imposing constraints upon the opportunities and occasions for tending to the self. It therefore seems that differing forms of care may conflict. That care 'giving' may undermine autonomy and an associated sense of self potentially disrupts a unified model of care. To date, there has been little consideration given to such a conflict in the debate on care, consequently privileging the standpoint of care providers over that of recipients.



In the conceptualisation of care, particular attention has been paid to that carried out within families. According to the bonds and obligations associated with ties of kith and kin, the vast majority of family care (usually chronic and unpaid) is provided more often than not, by women. Such care is characterised by the existence of a prior relationship between care provider and recipient. However, there is much variation in the willingness, consistency and quality of care provided as well as the resources available to support this relationship.

To date, there has been a focus of attention upon nuclear family networks, with 'collectivist' models of care located, and discussed, largely in relation to formal care (Dalley 1996). This despite the existence of a range of alternative informal networks, for example within religious communities and within the gay community. That such alternative networks of care may inform an elaborated model of informal care remains overlooked. The conflation of informal care with familial care has marginalised the perspectives, relationships and motivations of those who care outside of family structures. As such, little is known of how bonds and commitments arise within these alternative networks of association. It may therefore be argued that a notion of 'network care' is both a more inclusive term for informal caring relations, and holds greater potential for an understanding of the diversity of unpaid caring relationships.

Formal care (time-limited and paid) is marked by the absence of a prior relationship. Described by Thomas (1993) as 'contingent caring relationships', formal care is set up under specific service conditions for specified needs. Care 'brokers' (often institutionally supported) bring together the recipient and provider while defining and regulating the nature of care undertaken and retaining the power to both enhance and limit levels of support. This dominant but often indirect input suggests that formal caring relationships may be usefully understood as caring 'triads'<sup>9</sup>. For those recipients of care who have

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<sup>9</sup> The advent of initiatives such as direct payments may be viewed as a restructuring of this triad, offering greater opportunity to the recipient and direct provider of care to negotiate the nature of support on offer. However such negotiations are constrained by factors including the level of funds made available, over which neither have control.



access to private resources and capital there has always been a greater degree of leverage in the negotiation of what needs are met and how.

Another distinguishing feature of formal care is the status of care providers as workers with associated rights and requirements placed upon them. As workers, care providers' interests are distinct from those of their employer, they may engage in both individual and collective forms of workplace resistance and they are vulnerable to dismissal whilst also able to resign. As previously noted, network carers are less able to agitate collectively for improved conditions or remuneration; it is far more difficult for them to take sick leave and holidays or to 'resign' from their duties.

Such crucial differences suggest the need to consider formal care as distinct from other forms of care. While it is clear that a nexus of differing types of care are the site of a crucial form of gendered inequality, a unified model of care undermines an appreciation of what is specific to paid caring relations. A generalised notion of care impedes an endeavour to theorise the situated nature of care. It sets limits upon the potential to enable care workers to think reflexively about their practice and undermines the connections of carers, as workers, to a wider debate upon employment rights and relations. As previously noted, the blurring of divisions between paid care and network care may also serve organisational ends, facilitating the control and regulation of a caring workforce.

A conflation of differing forms of care also obscures the social and power relations that adhere to particular domains. As will be argued, within formal care the input and accountabilities of a wider organisational context have a crucial bearing upon the nature of care provided. Without a developed notion of this triadic relationship there are limits set to the potential to effect change and improvements. The relationship of care provider to recipient also differs markedly from that within network care, suggesting the worth of viewing formal care as 'care for others'.

In formal care situations, a recipient of care may be understood as 'other' in that they are not part of a wider network linking them to a provider over time. Often, their need for



support also leads to out-group membership, thus, Shakespeare (2000) has argued that a common factor linking groups of older and disabled people in receipt of care is that they are subject to social processes of exclusion, or 'othering'. Additionally, as will be discussed in this chapter, a recipient of care may view a provider as 'other'.

As previously discussed in relation to the histories of the Jewish community, charitable work has served as a vehicle to promote particular ideologies of gender and class and as an expression of superiority (Rozin 1999). Shakespeare (2000) has highlighted the 'ambiguities of altruism' that imbue charitable work, suggesting that there is a need to consider the dividends that accrue for those who undertake such forms of support.

Fieldwork for the present study offered an opportunity to observe the presence of volunteers within the care homes under investigation. Within a wider debate on care the meanings and significance of this distinct type of caring relationship have also received little consideration. While volunteers are often recruited and supported by formal care providers their relationship to these organisations and to service users differs from paid workers. Volunteers occupy a distinct position in the spectrum of care, they often provide differing forms of support, and as such may be viewed differently by service users. The inattention to such voluntaristic forms of care has set limits upon the development of a distinct model of such care. Clearly, this undermines an awareness of the particular contributions made by such carers but also obscures a detailed exploration of the motivations and meanings attached to such care for both providers and recipients.

### Perspectives on care

Given the evidence demonstrating that across cultures, across time and across differing social strata women predominate as those who 'do' care, a critique of care has proved an important feature of a feminist political agenda (Finch 1990). Care is a site for the construction of a gendered identity with femininity linked to care with a variety of outcomes socially, structurally and economically. An important dichotomy organising an understanding of care is that of caring for and caring about the subject of care and the



relationship between these two concerns. Waerness (1984) makes a distinction between 'personal services' and 'care-giving work' provided, usually by women, in the context of family reproduction. Personal services are carried out on behalf of those capable to undertake such activities for themselves, highlighting the subordination that is tied to the unequal division of labour within the home. By contrast, care-giving work is undertaken on behalf of those unable to carry out such tasks for themselves.

Graham (1983) argues that, labour and love combine in the provision of care, thereby highlighting the manner in which women are compelled to engage in this field of activity as the reproduction of the family is interwoven with love, affection and emotional support. Thus, gender has been centrally located in the debate on care, and this has served to shape the unfolding debate in a manner that highlights a common experience for women. However, as has increasingly been emphasised, this focus serves to downplay a host of differences, competing interests and social divisions between women.

An emphasis upon the gendered complexion of care, across a variety of settings has also been criticised as downplaying the very different nature of (unpaid) care undertaken at home and (paid) care in the public sphere (Thomas 1993). However, Ungerson (1990) argues that such a division represents a 'false dichotomy', given the association between these two fields of activity, for women, based upon an assertion that the nature of care provided is often consistent across this divide. Ungerson highlights the importance of understanding the family as a social institution, open to scrutiny and regulation and within which women are positioned unequally. The family therefore exists in the context of a range of institutional settings that structure and maintain gender inequalities. Conversely, Thomas (1993) suggests that this blurring of the division, between what should be understood as two distinct forms of support, highlights a lack of rigour in the conceptualisation of care. Thomas concludes that it is not possible to theorise a unified concept of care on the grounds that:

"Definitions of care are constructed such that boundaries are differentially drawn around what constitutes care, with the effect of excluding or including sets of social relations in definitions of caring relationships. In particular, concepts of care



tend to be presented as generic when they are actually specific to, and within, either the private or public domains." (Page 649, 1993)

This chapter will therefore explore the question of whether it is useful or viable to construct a generalised theory of care and the notion of a hierarchy of identities will be employed to address the issue.

### Femininity and Care:

An essentialist model ties women to care through an assumption that it is a natural feminine activity. Attention has been drawn to how an essentialist model of femininity and care has underpinned a great deal of policy, legislation and structuring of care provision, as evidenced by the lack of training offered to women entering care work<sup>10</sup> (Means and Smith 1998).

Psychological and developmental models, generated in order to explain a range of gender differences, have tied femininity to care in order to challenge arguments that girls develop more slowly than boys in relation to reasoning and moral awareness. Gilligan (1982) proposed that girls develop an 'ethic of care' that takes account of a network of perspectives and this is distinct to a masculine 'ethic of justice' employed in response to ethical dilemmas. This theory has met with criticism on the grounds that it overlooks the structural determinants that position women as carers (Graham 1983).

Attempts have also been made to highlight the manner in which women are socialised into the role of carer, developing the skills and attributes for this activity through common social experiences. Mason (1996) has argued that the experience of domestic, household, family and bodywork may lead to the development of skills and attributes employed in caring. Mason proposes that a combination of 'sentient activity' and 'active sensibility' are crucial components of the act of caring and women are more likely to develop these skills

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<sup>10</sup> Fieldwork for the present study highlighted that the staff who had the highest and most consistent level of contact with residents were those in the lowest grades. Given that these workers are the least well qualified members of the care team, this suggests a continuation of an assumption that caring is a natural attribute rather than a skill that is learned.



given their caring role within the family, However, Mason recognises the limits to such a model of care:

"It does not tell us why some women might become sentient actors in caring relationships with relatives while others do not, nor, importantly, why people may engage in sentient activity in caring relationships with some relatives but not others". (Page 31, 1996)

Linked to the process of socialisation is the formulation of sex-role theories. From such a perspective, women and men are viewed as socialised into identifiable (dual) roles, with caring an integral feature of a feminine role. Connell (1987) has offered a critique of role theory, highlighting the manner in which social 'norms' are constructed and the (value-laden) judgements attached to variation or deviation from such norms.

"Sex role theory simplifies the complexities of gender: sweeping all women into one feminine role, which in turn is equated to being a housewife and located within the family." (Page 51, 1987)

Role theory thereby constructs a static model of gender that fails to incorporate variation or change over time and overlooks issues of power in gender relations.

Theories giving prominence to the structural and economic dimensions of gender and care have argued that women's caring labour is exploited, with a variety of benefits to the state and a wider patriarchal society. Gardiner (1997) highlights the manner in which the family, as an institution, interacts with state policy and legislation, for example through the under-provision of nursery education and gender differences in parental leave entitlements. With regard to the interaction of informal and formal care, Ungerson (1999) has argued for the need to connect the undervaluing of paid care during a working life to a number of outcomes for women. It is argued that such low-paid work leads to poverty in old age and this resulting poverty will in turn impact on the consumption of care. Similarly, Arber and Ginn (1991) have argued that there is a gendered cost of caring. Women's network care responsibilities often lead to a discontinuous employment



pathway, which impacts upon pension entitlements, with 'non-state pensions the major source of inequality among elderly people' (page 381, 1991).

Employment statistics demonstrate that the presence of a dependent child in the family has a major effect on the economic activity of women (Summerfield and Babb, 2003). Income statistics reveal that the average weekly income for men is higher than that of women in all age bands. Overall, women's weekly income is only 49% of that of men, not least as a result of more women working part-time or shorter hours; 80% of all part-time workers being women (Summerfield et al 2003). Research in nursing has highlighted the manner in which part-time and temporary work impacts upon career advancement, including promotion and access to training. A study by Lane (2000) found that part-time workers were least likely to occupy the upper echelons of NHS nursing, and were often confined to the lowest qualified clinical grades. Whittock et al (2002) found that male nurses were far less likely to work part-time thereby advancing in their careers more rapidly than women. While a number of changes to the structural position of women have taken place, not least in the level of workforce participation, gendered differences regarding the responsibilities associated with care remain a decisive influence upon women's employment.

"This growth in participation should not be interpreted as a simple move towards parity with the male 'breadwinner' - it is a move that continues to place women's caring role centre stage but to expect that role to be performed in a way that includes earning money." (McKie et al, 2001, page 244).

Despite the validity of these accounts and the substantial evidence that has accrued to support the argument that women are economically disadvantaged by their participation in care at both paid and unpaid levels, a number of limits have been identified to this perspective. Graham (1983) has argued that such accounts fail to address the 'symbolic bonds' that tie women to care, or the differing sense of obligation that positions women as carers while men 'escape' this activity. An important aspect of this being the manner in which caring may be understood to have a defining influence upon women's social identity.



Perspectives that take into account the social and symbolic factors that determine women's participation in caring have highlighted gender differences in the sense of duty and obligation in relation to care. Finch (1989) has argued that commitments to care evolve over time according to a complex process of negotiation within families. Patterns of support are often based upon reciprocity that creates commitments over time, however, there exists an imbalance of power in the negotiation of commitments in which women risk their reputation to a greater extent than men, if they fail to provide care. Studies by Finch and Mason (1991, 1993) have highlighted considerable variance according to the specifics of different situations. The authors concluded that while women's obligations to family care appeared stronger, the evidence did not support the view that stable sets of values existed amongst respondents. Instead, the study revealed a 'hierarchy of obligations' related to spouses, parents and children.

Opie (1994) has similarly argued that gender differences regarding social obligation and familial duties, serve to position women as more likely to care within a familial context:

"In both instances, attempting to terminate, or refusing to accept, the obligation (to care) is difficult because the grounds for doing so are gendered, making them significantly less accessible to women." (Page 43, 1994)

However, in a critique of the debate on care, Opie has drawn attention to the lack of critical attention given to the underlying concept of gender, suggesting this undermines the conceptualisation of care.

"In the literature on caregiving, gender is typically understood in terms of sexual difference and a unified concept of 'woman'." (Page 37, 1994)

Further questions to be explored in this chapter, again employing the notion of a hierarchy of identities, will therefore be, to what extent is it viable to employ a 'unified concept of woman', in the debate on care? And, what limits does such an approach place on this unfolding debate?

### Gender and dementia care



Existing studies of gender and dementia care offer a pertinent insight into the debate on care, with certain characteristics of this body of research representative of the wider literature on care and gender. The weight of attention to gender and dementia care has focussed upon familial caring relationships. And, within these relationships the perspectives of care providers have proved the primary concern. Overall, these studies are notable for their discussion, at a general level, of the relationship of gender to care but without reference to formal caring situations or consideration of how formal care may differ from informal caring relationships. The majority of existing studies have drawn upon data generated from comparisons between small samples of mainly white, middle class carers. As an outcome of a comparative model, little attention has been paid to differences between men and between women, or the variables that may influence this.

Studies comparing carers and non-caregivers have found greater levels of reported burden and strain for carers as a group, but particularly for female carers (Almberg et al 1998, Rose-Rego et al 1998). A study by Barber and Pasley (1995) found that female caregivers reported greater declines in health, as a result of caregiving. Rose-Rego et al (1998) speculated that such gender differences signalled differing styles of caring, with a greater level of emotional attentiveness amongst wives and differing styles of coping, with wives more 'emotion-focused'.

Across this body of research the issue of emotion seems to be a particular theme, differentiating care by men and women. Miller (1990) found that while women's caring encompassed both emotional support as well as task completion, men were more 'successful' in distancing themselves emotionally from their wives' situations. Similarly, Rose and Bruce (1995) have highlighted the instrumentality and lack of emotional attachment in the care provided by men:

" ... we began to think of men's caring as a pet rabbit relationship. A pet rabbit's survival requires conscientious care; indeed its condition is a source of pride for its carer, and the well cared for pet, or rather its owner, receives much admiration. For



women, the husband with Alzheimer's fails to become an equivalent pet, so they grieved." (page 127, 1995)

A study by Ungerson (1987) found that male respondents derived the language of care and an approach to care from their prior occupational experiences, indicating that they perceived caring as similar to paid labour. However, in a more recent review of studies of male carers, Casalanti (2003) has argued "embedded within this depiction of men's style of care work as managerial and more like their paid work is often the image of a white, professional heterosexual man" (page 24, 2003).

Casalanti (2003) argues that it is important to consider how gender relations shape both the reporting and meanings attached to care for older men and women. It is argued that men who care often receive greater levels of support from a wider network when they undertake care, also that they may label a greater range of domestic responsibilities as 'care', in comparison to women. There is a greater likelihood that care work will shade into personal services offered by women and for this reason the overall absence of studies employing objective measures of caring work undermines recognition of such gendered variation.

While some studies have suggested that men and women care differently, others note gender differences in the reported outcomes of caring. Few studies have addressed the issue of whether such reported differences were viewed as a direct reflection of the caring experience or whether difference was located in how the experiences were articulated. However, a study by Fuller-Jonap and Haley (1995) found "that depressive symptoms do exist among male caregivers even though men may be more hesitant to express them than women" (page 113, 1995). A study by Ford et al (1997), which used objective measures of tasks undertaken and symptoms of the recipient of care, found that while women were more likely to become carers, they:

"Provided neither greater overall care nor greater assistance in personal care or household tasks.' ... 'The present findings support the contention that gender roles may be subsumed by the press of caregiving demands in the case of providing care for a family member with dementia." (Page 162/3, 1997)



Emerging from this set of comparative studies appears to be a consensus that differences exist in the reports of care given by men and women, based upon comparisons between the two groups. However, the differences cited vary between studies and include; level of burden or strain, relational outcomes, health and psychological effects and what factors motivate care. There is less clarity as to whether this reflects differences in the actual activities undertaken. While some studies have used these reported differences as the basis to conclude that men and women approach care differently, few studies have demonstrated this through 'objective' measures. Neither is it clear how differences in reported burden are linked to the 'caring about' aspects of these relationships.

Three areas of potential gender difference have been highlighted by these studies: care tasks undertaken, subjective accounts of burden, and emotional attachment in the caring relationship. While clearly interacting these distinct aspects of the caring relationship appear ill-defined. Consequently, there is little evidence of a consensus regarding any clear divergence between 'masculine' and 'feminine' models of care. Indeed, a meta-analysis of research into gender and dementia care by Miller and Cafasso (1992) reported a wide variation of findings between studies. Overall, the study found 'limited significant effects for gender', other than a 'small effect' with regard to women being more likely to report greater burden than men.

None of the above studies sought to elicit input from the recipients of care, suggesting that neither care, nor gender is deemed relationally constructed. A static model of gender thereby underpins much of the research in this field, with little attention to how caring relationships may alter over time, or whether gender relations may undergo negotiation as part of this. Yet, a study by Miller and Kaufman (1996) highlighted an interaction of gender and care; the authors suggested that carers holding 'gender-stereotypic' views of sex roles faced greater challenges when renegotiating these views in light of the requirement to care. The study also found that the type of caring relationship was an important influence upon attitudes to caring. A study by Hanson (1994a) that included both same-sex and mixed-sex caring relationships found that the person with dementia



was uniformly disempowered within these relationships and suggested that a 'gender dynamic' underpinned this process. Hanson argues for the need to understand gender relationally, suggesting that sex-based differences are inadequate for explaining how this process is negotiated.

"Given that the sex of individuals involved in a particular part of the pattern does not seem to alter the pattern (of disempowerment) itself, it is the gender dynamic and not the attributes of the individuals which deserves attention." (Page 65, 1994)

Research paying attention to the type and quality of relationships has also highlighted the influence of these factors upon outcomes for carers regarding levels of stress and burden. Studies of marital relationships involving the care of a person with dementia, suggest that a close pre-morbid relationship influences the willingness to care, the emotional content of care, (Morris et al, 1988) and the way in which meaning is attached to the behaviour of the person in receipt of care (Lewis 1998).

This review of studies addressing gender in the context of informal dementia care has highlighted a marked degree of variance. Of particular note is the diversity in how gender itself is conceptualised with clear implications for methodology and subsequent analysis. From the studies considered, gender appears in a number of forms:

- As sex-roles, in which care is 'sex-marked' as a feminine activity, with men and women thereby differently equipped to provide care.
- As an explanative of who cares and why, with regard to the range of structural, social and symbolic determinants that position women as more likely to care.
- As a component of identity, with the uptake of care supporting or undermining biographical continuity.
- As a relational construct or 'dynamic' that is negotiated within the context of a caring relationship.

Given this diversity, whether it is viable to view these studies as a coherent body of research that combine to support and confirm gender differences regarding the provision



of dementia care, is open to question. Furthermore, the lack of attention to in-group differences that include issues of 'race', culture, ethnicity, class, age and sexuality arguably masks the importance of these influences as they interact with gendered experiences of care. A focus upon gender as the primary variable differentiating the samples within these studies raises the question of whether gender norms are revealed within this research or, imposed by the methodology.

### Dichotomies

The lack of direct attention to the gendered nature of care in much policy and legislation has served to mask the social politics and inequalities that adhere to this type of activity. As previously noted, feminist deconstruction of the notion of 'community' provides an example of how official and socially authorised representations of care have failed to engage with the underlying politics of how need is met and by whom. A starting point for any consideration of care provision and receipt must therefore be the recognition that care is a contested issue, and the site for a debate in which differing perspectives and interests compete. As this debate unfolds, so a number of key dichotomies have evolved to shape the ensuing construction of 'care'.

#### Masculine/Feminine: Network care

Graham (1991) has argued that, equal consideration has not been given to the full variety of conditions or caring relationships. Thus, attempts to extrapolate from what Graham describes as 'home-based, kin-care' require attention to the arguably crucial differences associated with how, why and where care is undertaken. Arber and Ginn (1990, 1997) and Fisher (1994) have highlighted that a focus upon intergenerational has care overlooked that older people undertake a great deal of care themselves, and that a substantial proportion are men. In exposing this oversight masculinity has been introduced to the debate on care, at least with regard to informal spouse care. The General Household Survey 1985 revealed that while 15% of women held caring responsibilities, 12% of men



were also involved in care<sup>11</sup>. The finding that a quarter of all informal care provided to older people was undertaken by men was viewed as an important consideration raising questions over the prior emphasis given to caring as a feminised activity.

"It was the later focus on spouse care which began to disperse the primary notion that 'care' was a particular domain of women as opposed to men". (Ungerson, 1999, page 4)

The inclusion of masculinity in the debate on care prefigured a number of studies that sought to compare the care undertaken by men with that carried out by women. These comparative studies, highlighting gendered differences in the nature of care provided, and subsequently different outcomes for male and female carers, have served to construct parallel notions of feminine and masculine care. The question arising from these studies, is whether gender serves as an explanative for the nature of care provided. While a host of social, structural and economic determinants mean that men are more likely to 'escape' the requirement to care, does it necessarily follow that, when they do care, the nature of this activity is qualitatively different from the range of approaches employed by women?

A characteristic of a great deal of existing research into gender and care is the overall absence of men and an inattention to interactions of masculinity with care. A potential pitfall with regard to the study of gender and care, but also applicable to care policy and practice, is therefore the risk that feminised 'norms' may serve as the yardstick against which men's experiences or attributes are measured and evaluated (Thompson 1994). As the above review of research in relation to informal care for people with dementia attests, within many studies of gender and informal care, 'masculine care' has been compared to and often negatively judged against a feminine model of care (Ungerson 1987, Rose and Bruce 1995). Russell (2001) has suggested that such comparisons inevitably underplay the heterogeneity of caring across diverse groups of both men and women and fail to address the meanings of care as the 'actions of ageing men' (page 353, 2001).

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<sup>11</sup> Arber and Ginn (1997) have drawn attention to how wording of the questions in the survey may have influenced these statistics.



It may therefore be argued that a problem exists at the level of an association of gender with particular models of care. The engendering of different approaches to care, such as instrumental vs. relationship-oriented care has led to value judgements being applied not only to differing care practices but also to men and women, as carers. Overlaying various approaches to care with a dualised model of gender also upholds a static model of gender. At the same time, such engendering has led to the dichotomising of arguably overlapping and interwoven aspects of care. If gender is understood as fluid and contextually negotiated then gendered models of care become problematic when particular experiences or attributes are generalised. If an instrumental approach to care is to be viewed as a masculine norm, then this must be demonstrated across a range of situations and for differing groups of men. Similarly, an emotionally attentive and relationship-oriented approach to care must be shown to be associated with women as carers across differing groups and contexts. This chapter will therefore seek to investigate care as a situated practice. Specifically, it will be argued that a number of variables intervene to problematise generalised accounts of gender and care.

#### 'Care for others':

For the present study, interviews with a largely female sample of care workers (n.= 26 women, n.= 6 men), included questions in which respondents were asked to give an account of what they saw their role as carer to involve. Interviewees offered accounts not only of the various duties required of them but also some insight into their approach to care and the model of care informing their work. Four main approaches were highlighted here:

##### 1.) Task-oriented

- "What do you mean by caring?"
- "Make sure they're, same as everyone, make sure they're washed, dressed, changed, fed." (rhcc7(f))



"Looking after them, yeh, make sure they are dressed properly, make sure they take their medicine on time, make sure they go regularly to the toilets." (rhec19(f))

"We've got to do their washing, feed them, change them, mostly to do with their personal hygiene, you know and feeding basically.' ... 'Most of the things we talk about are to do with personal hygiene and feeding". (rhac8(f))

## 2.) Professionalism

"My role as a nurse is to make sure the safety is paramount, while I'm here and to look after the health. To provide them with all their needs if I can and just provide a safe environment." (rhac8(f))

"I plan their care, supervise the carrying out of the (care) plans. Supervise the staff and I'm an advocate for the residents within my team specifically and I'm key-worker to two of the residents." (rhlc15(f))

"I don't regard myself as a psychiatric nurse here because I was employed as an RGN. But whenever we have anybody with Alzheimer's or they've got a bit of confusion and other psychiatric traits, I normally go to my colleague 'you've got to do this, can we get the doctor to prescribe this, or come?' you know, just to be helpful". (rhlc32(f))

## 3.) The promotion of independence

"My role is to enable them to live their lives, not to live their lives for them, to help them in their day-to-day living really." (rhbc20(f))

"Promoting independence so that, you know, giving them my help but encouraging them to do more for themselves." (rhec16(f))

## 4.) Relationship-oriented care

"To give them all the care, I mean, like, I see them, and most of my colleagues we refer to them as mum and dad, because we feel that we're part of the family and that's the care we give them, as if they're our family, our mothers or grandparents, that's how we see them." (rhec18(f))

"(To be) their friend." (rhfc23(f))



"You try to be like them, you know, friendly. You got to trust them and got to be friendly, so you can understand them and also they can be free to you." (rhbc6(f))

Those respondents who highlighted more negative approaches distanced themselves from such models of care.

"A lot of people can do the job quite easily, but I think they blank a lot of it, emotional stuff, out and see it more as a physical job. As long as the residents are clean and washed and having something to eat and they're perfectly well." (rhec16(f))

"I didn't like some of the staff for the way they treated the clients, but they wasn't treated like that in front of officers and that, it was behind their back. But I didn't like it, but I couldn't say anything because I was only a carer like them." (rhfc23(f))

With regard to the approaches to care signalled in the responses of this largely female sample of workers, all employed and trained by the same organisation, what is most striking is the diversity of perspectives. While some care workers spoke of a close bond with residents, suggesting that their caring relationships were premised upon 'false-kin' relations (Gregson and Lowe 1994) with a clear indication of the 'caring about' aspects of their work, other carers signalled a more instrumental, task-oriented approach to their work. This finding suggests that models of care based upon a dichotomy of masculine and feminine approaches, seeking to emphasise in-group commonality, are inadequate to account for such wide variation, at least with regard to formal care. Contained within these responses are models of care that elsewhere have been marked as either feminine or masculine in prior studies of network care. Instead, the findings suggest that a range of factors may influence the development of approaches to care and, to date, these have been given only peripheral consideration in the debate on care. The lack of attention to these intervening variables serves to undermine the explanative power of studies that isolate gender when investigating care.



To what extent formal, 'care for others' may lead to approaches to care that differ from network caring relationships is an important consideration, not least in regard to the extent to which a mode of care is chosen or imposed in formal care situations. The professionalism, signalled in a number of the responses points to a view of care as upholding a range of organisational and institutional requirements. This would appear to challenge the suggestion that the divide between informal and formal care represents a 'false dichotomy', given the importance of the influential but indirect input of the wider organisation into how care is structured and provided. At present, formal care is often 'read' through findings from research into informal caring relationships and it may be argued that this body of research provides an inadequate model for understanding the very different relations that pertain to care for others.

Masculinity/femininity: Employment and 'care for others':

A number of challenges and potential pitfalls exist when investigating gender and care. One such challenge, pertinent to the present study, arises from the demography of care. As has been shown, women predominate within the formal care of older people, both as providers and recipients of care. For this reason, any study that fails to take account of gender runs the risk of overlooking men and masculinity in care, particularly so when seeking to identify patterns or norms across this population. The absence of existing research addressing gender in the field of formal care for older people may thus be understood as leading, inadvertently, to an understanding of such care that is weighted in favour of women's experiences and perspectives and the creation of feminised norms.

The construction of a weighted perspective is an issue that the present study must actively negotiate. Within the design of the CPCEC project, the data from which this present study relies, there was a concern to proportionally represent the gender mix of both carers and residents. As such, the minority status of men in care has been replicated by the sampling for the study. Indeed, following the consent gathering process men were found to be under-represented within the study, suggesting a gender effect upon the sampling process.



A number of issues arise from this, including the need to show caution when generalising from such a numerically small sample of men.

Far less attention has been given to a gender dichotomy within formal care provision. As a gendered field of employment, little attention has been given to men who are paid to care. Studies that address care in formal situations are characterised by an assumption that workers are female, not least in considerations of how formal caring connects with network care responsibilities.

No overall statistics exist detailing the proportion of men across the population of workers in independent sector care jobs. The present study suggests that men constitute a small minority of the overall workforce for Jewish Care; 16% of care home workers. Also, there is a clear indication of gender segregation within this workforce according to the type of work undertaken. Of the 29 men randomly selected for the CPCEC project, 14 (48%) were employed in a non-caring capacity, for example as domestic workers, laundry workers and in site maintenance. By comparison, of the 94 women selected by the project, only 21% were employed in a non-caring capacity.

In a study investigating women's experiences in male-dominated fields of employment, Eveline (1998) identified a number of narratives that served to maintain men's advantage at work. Eveline found that male employers and employees invoked 'heavy, dirty and limp stories' to 'explain' how women were physically and psychologically unfit for certain types of work. The study drew attention to the hierarchy of identities within predominantly male types of work, arguing that the gendering of skills, within these narratives, served to undervalue women's work. The study also highlighted how embodiment was a source of disadvantage for women, who were perceived as not strong enough to undertake certain types of work and were not provided with adequate facilities, such as separate toilets and showers.

In contrast, a study of men in predominantly female fields of employment has argued that their token status provides a source of advantage. Williams (1995) argues that men carry



their 'gender privilege' into jobs that are predominantly female. Despite this, they are subject to masculine stereotypes, for example, the expectation that male teachers will have greater authority in relation to pupils. Williams also noted a number of strategies, employed by men in order to 'demarcate and distinguish themselves from their female colleagues' (page 122, 1995), not least as a means to maintain a sense of masculinity that is less directly upheld in the work they undertake. However, within feminised work environments, such as education and nursing, men were found to be concentrated in certain areas, such as the upper age groups in teaching and in the psychiatric field of nursing.

In a study of men working in nursery education, Cameron et al (1999), argued that nursery care is premised upon 'mother care' and as such men were often viewed with suspicion while, paradoxically being 'glorified' for having entered such a field of work. The study found that while female workers were judged according to their professionalism, male workers were viewed according to gendered beliefs and were therefore under scrutiny, not only with regard to their working practices but also in relation to attitudes regarding masculinity. Male workers experienced restrictions in their work, this included expectations that they would perform certain 'roles' in relation to the children they worked with (substitute father, positive male role model, compensating for deficient fathering). While at the same time being excluded from 'touch' jobs, such as providing personal care.

A study by Lupton (2000) in which men working in predominantly female work forces were interviewed, found that gender segregation was maintained through 'active strategies of exclusion and demarcation'. Men interviewed for the study were found to employ a number of strategies to negotiate their masculinity at work, which included reconstructing their occupation to place emphasis upon masculine aspects of the work, while down-playing the feminine. With regard to nursing, Baxter (1988) has highlighted the interactions of gender and 'race' in which Black male nurses were placed in specialisms or work situations "in which the emphasis is on physical containment rather than therapeutic nursing" (page 47, 1988).



Given the overall low numbers of men employed as care workers within Jewish Care, respondents were asked whether they felt that their workplace would benefit from having more male workers. Out of 29 responses (n.3 = information missing), the largest proportion of carers (13/45%) cited the wishes of a largely female client group as a reason why there should be no increase in the numbers of male workers. In particular, respondents noted the resistance of female residents to male carers providing personal care and the need to 'preserve their dignity' in this respect.

"Having more male staff would create more problems than good because so many of the women can't be done by male staff and when you have a lot of male staff you put pressure on the female staff, they will have to do a lot because only they can do." (rhec1(m))

"You find that some of our female residents totally refuse for being looked after by a male and I think that it is fair because I wouldn't want to have a male carer look after me." (rhac3(f))

A number of respondents noted that both men and women prefer to be cared for by women, signalling a perception that residents held the belief that women are naturally better at caring and perhaps that 'mother care' prevails in such settings.

"Most women prefer females, but most men are happy with females looking after their personal care, so we can't really (have more male workers), one on each team is probably enough." (rhcc21(f))

"It's just that it's alien, I mean a man looking after them, a man seeing to their private bits, yet a male would prefer a woman, so I don't know what you'd do." ...  
"There are men who prefer men but there are men that prefer a woman, it's not because they're queer or anything, it's just that they reckon that a woman is more gentle and a lot of women are embarrassed by the thought of a man". (rhfc23(f))

Two workers interviewed in one home pointed out that it was the policy of the home not to employ male carers, following a vote by residents. The exclusion of men, from care, therefore being upheld at an organisational level. However, one respondent noted the implications of this for the small minority of male residents within the home.



"I think the male residents, perhaps in that respect, have had their wishes taken away, haven't they? Because they're probably thinking 'well, why do I have to have a woman all the time shaving me, bathing me', you know. But it's like everything in life, isn't it, majority rules in a lot of ways as the majority is female here, you know". (rhjc17(f))

Of the eleven interviewees who indicated that it would be of benefit for there to be more male workers, the majority cited the reason that this would better meet the wishes of male residents, again, with regard to the provision of intimate care.

"We need male staff, some of the residents, some of the men don't like when they see a woman, they won't co-operate, so we definitely need a male staff, yes". (rhec19(f)).

"Some of them are shy, some of them don't want a woman to see their naked skin". (rhec19(f)).

Two respondents referred to the social benefits to male residents of the presence of male carers and the opportunities their presence offered with regard to male residents being able to talk more openly in same-sex interactions. However, overall, the benefits of the presence of male carers appeared to be measured according to numbers of male residents in each home. There is a clear indication here that the preferences of residents, regarding the provision of intimate care were perceived by staff as a decisive factor in the recruitment of male carers. Fisher (1994) has noted a similar issue in relation to community care.

"The concept of a gender boundary means that it is not sufficient to construct the debate about gender and community care simply in terms of the gender-specific expectations and preferences of the carer, but must include consideration of the wishes of the recipients of care". (Page 676, 1994)

A study by Arber and Ginn (1995b) noted the operation of a cross-sex taboo in personal care within informal caring relationships. The study found that while cross-sex care was often practised within spouse caring relationships it was restricted in relation to care provided in another household. The authors argued that this taboo applied differently, according to gender:



"The cross-sex taboo may be greater in relation to men caring for dependent women than women caring for dependent men: the latter can more readily be acted out in terms of a mothering relationship or nursing role. " (Page 21, 1995)

The authors conclude that state-provided care therefore has a particularly important role to play for supporting caring relationships where the caregiver is of a different gender to the care recipient. However, as the present study suggests, the cross-sex taboo appears to be carried over into formal caring relationships and to reinforce the exclusion of men from care settings in which female clients are in the majority.

Echoing Lupton's (2000) finding that men reconstructed their work to emphasise masculine aspects of a feminised job, two of the male carers reported the perception that men were able to bring distinct qualities to caring.

"Sometimes, when there are men about, they, um, I don't know, I don't want to sound sexist, I must be careful, they can actually instil, in inverted commas, level-headedness. It sounds very sexist that comment, but it's not meant to be."  
(rhkc2(m))

"It helps if, um, one of the female staff have problems moving a resident, they could be either a bit too heavy or awkward to move, then they ask one of the male staff for a hand. Not being sexist, you know, but the strength side of it, I mean it's not force, it's just help. We don't just drag them, it's careful lifting you know."  
(rhlc(m))

An interesting aspect of the 'reconstruction work' taking place in these responses, is that both are accompanied by the stated concern of not being perceived as sexist while signalling the belief that men are able to bring distinctly masculine psychological or physical attributes to care. This demonstrates the manner in which the interviewees are orienting their accounts to a third party. Interviews with care workers offered an opportunity to present a public account of themselves as carers. The manner in which their responses were organised and the information they chose to make known about themselves and others therefore represents the public face of their working identities. Of



particular note for the present study is the manner in which gender mediates these public accounts.

The closing statement by the interviewee above: 'We don't just drag them, it's careful lifting you know', offers an illustration of this identity construction. While highlighting the 'heavy narrative' (i.e. men are better placed to undertake care work that involves physical strength), the interviewee shows a concern to differentiate this masculine attribute from a 'rough narrative' (i.e. that men are less likely to be gentle in their work). Later in the same interview the respondent again shows a concern to 'inoculate' his working identity from a possibly negative interpretation. The interviewee actively seeks to distance himself from a 'rough' narrative, demonstrating a concern that men in care may be perceived as less careful or gentle:

"Because we're not allowed to use any restraint on them, which is obvious, no force or anything, so the most force we're able to use is like a belt in their wheelchair so they can't fall out." (rhlc30(m))

Further on, in the interview, the examples the respondent chooses to recount as part of this self-presentation serve to emphasise the authority that he brings to his work:

"The other night there was just two residents who was still up and one wanted to watch BBC1 and the other wanted to watch ITV and they're arguing, so I'm not being nasty but I said 'you carry on the way you are and the telly goes off. This programme's on again next week so she can have it on then and you can have that one on now.'" (rhlc30(m))

With regard to physical strength, four female respondents also noted this as a particular benefit of having male care workers present.

"With the men, we find that the male carers can, because the men are very strong, you know, they're very strong and the men can usually handle them better, you know, if they grip hold of something there's no way you can move them, you know." (rhcc24(f))



"I think maybe with the manual, with the lifting and things like that, the moving, it would be nice to have one male staff on like each shift." (rhec14(f))

Of particular interest in these responses is the indication that male carers are positioned to tackle certain tasks and take on particular roles within the care environment, according to their gender. This echoes the findings of Cameron et al (1999) where male nursery workers reported being 'encouraged' to take on practical tasks in their work environment. Thus, what men do, as carers, appears mediated by gender, not least with regard to how they are called upon to assist female workers.

In contrast to these responses, three respondents indicated that gender was not a factor in the provision of care, highlighting, for example, that an individual's ability as a carer was more important.

"I think it's the approach really, because there are some male staff who don't know anything about the resident and (that) makes them worse' ... 'it's the way they deliver the care, I think, it doesn't matter". (rhec10(f))

Two female respondents specifically resisted the 'heavy' narrative indicated by other respondents, in relation to the benefits of having male carers.

"If the resident need to be done by two people, it's the same thing. Like we're working two, if the person is two people, so I don't really see the difference of the male staff and the female staff, they're all the same". (rhec26(f))

"If you have a heavy resident then it will be easy for us to deal with the heavy resident, I mean we don't have any difficulties because we've got the equipment, which is quite good." (rhdc28(f))

With regard to male care workers and the work they undertake, two issues of particular note emerge from this interview data. Firstly, the perspectives of the recipients of care appear to have an important influence upon the type of care undertaken, not least with regard to personal care. This factor proved to be an important measure for respondents in judging an appropriate gender balance within the staff group. It was given greater weight in the responses than beliefs that men would provide a differing type of care, or of any



consideration of the social benefits to the minority of male residents. The 'gender boundary' operating within care homes therefore serves to regulate the number of men present and, in one instance, this was upheld at an organisational level through a formal exclusion of male workers.

Secondly, a male worker's physicality appears to influence the type of input they are called upon to provide, suggesting that the nature of their work is interactionally constructed according to 'heavy' and 'authority' narratives associated with masculinity. However, the extent to which some respondents resisted these narratives leaves open to question whether this may be understood as a gendered culture within the care homes under investigation. The finding that only three respondents viewed the skills of individual care workers as over-riding issues of gender, points to the gender of workers as having an important influence upon how they are judged and treated. In the case of male workers, this places certain restrictions on the nature of the care they are called upon to undertake. Such restrictions are influenced by the gendering of care, both by residents and carers, consequently problematising men's presence within these settings.

#### Formal/Informal:

The advent of community care, supported by a number of legislative and policy initiatives, has met with a mixed response, not least in regard to the wider debate on the politics of care. An important strand of the feminist response to community care has been a concern to highlight the implications for women, as informal carers. A number of commentators (Ungerson, 1987, 1990, Dalley, 1996 and Finch 1984) have argued that community care policies have served to compound women's subordination and exploitation, given their predominance in network care. With good reason, community care policy has been criticised for the stated expectation that care will be provided by families and the implicit expectation that women will extend their network caring responsibilities, thereby compounding inequality.



"Socializing the costs of dependency through welfare state programs represents a great opportunity to ameliorate inequalities. By contrast, locating dependency within individual families serves as yet another method that sustains, and even magnifies, socio-economic inequalities." (Meyer, 2000, page 3)

One response to community care policy has therefore been the call for an expansion to formal care provision. As a non-sexist alternative to community care, Finch (1984a) has argued in favour of residential care for older people, pointing out that such a 'collective' response would serve to recognise care as labour while creating employment opportunities. Her argument is premised upon a construction of older people as a social burden, unequally shouldered by women as carers:

"There is a particular urgency about this task, given the rising numbers of elderly people in the population between now and the end of the century." (Page 16, 1984a)

Similarly, Dalley (1996) has argued for an expansion to formal care, as a collectivist response to care in society and as an alternative to the 'possessive individualism' that places emphasis upon care by the family, i.e. women. Studies by Ungerson (1987, 1990) have also called for the replacement of informal care with formal caring arrangements, in relation to both older and disabled people. Ungerson has argued that an unsubstantiated assumption underpins the polarisation of formal and informal care:

"In one, they seem to argue, loving relationships prevail to the exclusion of all other considerations, and in the other, monetary, contractual and bureaucratic relationships prevail and love and spontaneity are absent'. (Page 24, 1990)

The promotion of formal care, as a means to challenge the subordination and exploitation of women, has met with some criticism. As will be discussed below an important aspect of this criticism is the lack of consideration given to women as the recipients of care. Another issue raised by the promotion of formal care, and the challenge to the 'false dichotomy' of formal/informal care, is the assumption that care provided under formal, service conditions, is comparable to that provided within networks. The question therefore



arises: in what ways is it useful to link the underpinning motivation and activities comprising informal care with formal provision?

Ungerson asserts that there is a lack of evidence to support a disassociation of formal and informal care, both in terms of what motivates care and the nature of care provided. In a critique of a scheme making use of volunteers to support older people in the community she argues:

"That care-giving work in both domestic and more formal domains can and does consist both of labour and love - is by schemes such as these, implicitly and totally denied. This is logically absurd and empirically unfounded. Such assumptions certainly need testing'. (Page 21, 1990)

However, data generated from the study of the institutionalised care of older people with dementia represents a considerable body of evidence that suggests certain formal care settings have an important bearing upon the nature of care provided. There is a remarkable consensus in the field of research pertaining to the experiences of care for older people with dementia. Such consensus is remarkable on the grounds that, like findings have been generated over a period of time, during which considerable changes to welfare policy and legislation have been witnessed. Also, because like findings have been generated across Europe and North America, thereby traversing a variance in welfare systems and associated 'cultures of care'.

A repeated finding for many studies across a number of different care settings is the low level of activity and stimulation on offer to residents/patients. Hallberg et al (1990) found that people with dementia in institutional care were engaged in minimal levels of activity and lived largely in social isolation. This finding has been repeated by a number of further studies (Bowie and Mountain 1993, Gilloran et al 1993, Nolan et al 1995).

An observational study of the institutionalised care of severely demented residents (Edberg et al 1995) found a disjunction in the mode of communication between carer and care-recipient, the former being task-oriented while the latter were more person-oriented.



This disjunction was seen as minimising any potential reciprocity with nurses displaying very low expectations of the communicative abilities of residents.

Iwasiw and Olson (1995) found that communication over care activities was the predominant topic of interaction between staff and residents. In contrast, those topics which received little attention during the period of observation were; 'patients' social systems, reminiscences, current affairs, orientation, feelings, plans and hopes' (page 417, 1995). The study identified a conflict over what residents saw as valid and worth initiating compared to carers, who controlled much of the interaction. Qureshi (1990) has suggested that an underlying conflict may therefore characterise the provision of care to older people:

"If it is thought that practical assistance provided informally is not replaceable by formal help, without an accompanying reduction in it's value to the elderly person, then this suggests there could be a conflict of interests between elderly people and informal carers." (Qureshi, 1990, page 61)

At the heart of the debate on the dichotomy of formal/informal care is a tension between an emphasis upon commonality and the recognition of difference. The promotion of formal care as a response to the inherent sexism of community care policies has placed emphasis upon gender and the shared interests of women across differing social strata, given their unequal participation in network care. However, this emphasis has been challenged as masking crucial differences between women and in how they are positioned in relation to care. The assumption that formal care may represent a 'solution' to exploitation has been framed within a debate where limited consideration has been given to issues of class, 'race' and disability. This being despite growing evidence that formal care is a class-based and racialised field of employment.

Class:

Jewish Care offers what it describes as competitive rates of pay, with (at time of writing, October 2002) basic grade residential care assistants offered £5.35 per hour, group leaders



£15,000 p.a. and RGN's £19,000 p.a. These rates of pay, especially for lower grade workers, are at a level with that offered by a wide range of service sector employers, including the hotel and catering industry, domestic services agencies and supermarkets. Valins (2002) has argued that such salary rates place independent sector care organisations in direct competition with these other service sector employers.

This income offers some insight into the location of care workers within the class system. However, gauging social class directly from income levels is problematic. Differing fields of employment may be understood to garner varying levels of cultural capital (Bourdieu, 1984), with the care of older people, considered a 'Cinderella' client group, carrying limited levels of such symbolic worth. As one respondent noted:

"A lot of people who don't do care think that it's got to be the worst job in the world, because you have to look after older people, so obviously it means hygiene reasons and stuff like that. A lot of people wouldn't go near a job because of that."  
(rhec16(f))

This response signals the social taboos associated with dirt and the requirement of care workers to engage with the dirt and waste of others. It offers an insight into one of the reasons that care of older people is viewed, socially, as having limited cultural capital or status as a form of employment.

Class may also usefully be understood as layered. The employment opportunities of working class women are constrained through the connection of class and gender. As will be discussed below, class also interacts with 'race'; Phizacklea (1983) has argued that Black and ethnic minority women are under-represented in low paid 'white blouse' service sector jobs.

In a study of waged domestic labour in various parts of Britain, Gregson and Lowe (1994) have argued that "the waged domestic labour force, is one which draws on a range of differences between women, notably those of class and life-style" (page 123/4, 1994). The authors noted that while women maintain primary responsibility for familial care, a



growing number of middle class women are now able to employ other, mainly working class, women to undertake many of their domestic and care responsibilities. The growth of dual-career families has led to a widening gap between women of differing classes:

"Rather than all forms of domestic labour being identified with all women, a class-mediated hierarchy of domestic tasks is once more being constructed" (page 233, 1994).

Emerging from this study is the recognition of a need to look beyond generalisations regarding gender and employment, paying close attention to the manner in which the employment market differentiates between women, even within the range of low-paid, service sector jobs.

"Specific service industries seem to be characterised by labour forces comprising different categories of women. One only has to think, for example, of the retail sales staff associated with certain clothes shops, or those used by large department stores to market and sell perfumeries and compare them with the staff of residential care homes or the schools meals service." (Page 128, 1994)

Class was found to interact with age, with older working class women mainly confined to jobs involving commodified forms of domestic labour, including care work. A study by Graham (1991) investigating waged domestic labour in relation to home-helps, similarly highlighted the racial and class divisions between women.

Waerness (1984) notes that women are disproportionately represented in the lower levels of the hierarchies of public care-giving organisations. Thus, the increasing professionalisation of care has a number of disadvantages for working class women as a result: "For the clients, the care services become steadily more fragmented. For the workers at the bottom, the work becomes more routinised" (page 83, 1984). It is therefore important to consider the implications of social difference in relation to women and formal care, as this area of employment appears to problematise a 'unified concept of woman'.

Immigration:



A striking feature of the sample of care workers randomly selected for the CPCEC project was the demographic specificity of this group. Predominantly women, the majority of workers were from ethnic minority communities. Additionally, 69% (n. = 22) of these workers were first generation immigrants, this included ten African workers, five from the West Indies, four from the Philippines, one Sri Lankan and two Irish workers. This sample reflects that of similar studies of care workers in urban areas of the UK. A recent study of home care workers noted:

"The London labour market is strongly racialised and a large proportion of the London careworkers were black. In addition there was evidence of an earlier racialisation, in that many of the older white women workers were Irish." (Twigg, 2000, page 124)

Fieldwork in five of Jewish Care's homes also revealed that the ethnic mix of workers in different homes varied according to location. Previous studies paying attention to the nationality of migrant workers in health care employment have also highlighted this varying pattern of distribution (Doyal et al, 1981). This may be understood to indicate that care homes are tapping into local immigrant communities. It may also be an indication that workers are employed relatively close to home, highlighting the interaction of formal and informal care responsibilities and the constraints that network care responsibilities place on job choice.

When considering the experience of immigrant workers in the UK employment market it is important to recognise the interaction of immigrant status with factors such as 'race', culture and ethnicity. Immigrant workers fare differently according to 'race' and ethnicity but also according to level of education, qualifications and, importantly, gender. Immigration may be understood as a sex-selective process. It is therefore also useful to consider the status of immigrant workers in the wider context of a global employment market and relations between developed and developing countries.

At a global level, Richmond (1994) has highlighted the fact that while there is a free movement of information, goods, services and money, with multi-national corporations



able to site production in developing nations where labour costs are low, a similar freedom of movement does not apply to labour itself. The national borders of affluent nations are increasingly being closed to economic migrants and political refugees.

"The economically developed countries are practising global apartheid through their restrictive immigration and refugee policies. The select few who are deemed admissible because their skills are needed, are exposed to the prospect of further systemic discrimination, personal prejudice and structured inequality when they attempt to settle in their new country." (Page 115, 1994)

Immigration is regulated according to the labour needs of host countries. Thus, immigration legislation has been shown to interact with national economies and in particular the need to meet employment shortfalls in certain industries. Research investigating immigrant workers in the health service has highlighted that they are often to be found concentrated in jobs for which it has traditionally proved difficult to attract indigenous workers (Doyal et al 1981, Culley et al 1999). As such, immigrant workers suffer disproportionately from factors associated with low-paid and unskilled work, including poor working conditions and employment vulnerability during periods of recession and economic down-turn.

Globally, women account for approximately a half of global migrants and are in the majority in migration to developed countries. Despite this, Sharpe (2001) has argued that mainstream accounts of migration have overlooked the specific issues relating to women migrants, based upon an assumption that the typical migrant is young, single, male and economically motivated to move.

"Women experience social and economic pressures differently from men, and they often migrate as a result of divorce, which can result in losing the right to land, or the death of a parent, meaning they need to send money to the widowed parent, also premarital pregnancy or infertility." (Page 7, 2001)

An account by a migrant, domestic worker, interviewed for the CPCEC project offered an insight into how network responsibilities are managed and maintained transnationally:



"When my parents (were) alive, I am working here and when they (got) sick my children look after them. So, if I can't do it my children do it. They live with them, if I'm not in a position to do it and then I send them anything they want, or whatever, 'til they die and when they die they call us to come and that's the way I brought them up. And then I bring my children here because nobody is at home."  
(rhknc3(f))

Phizacklea (1983) has argued that migrant women occupy a subordinate position within sectors of 'women's work' and cites the concentration of immigrant women in the least desirable sectors of nursing as evidence of this. Phizacklea argues that migrant women's employment experiences are distinct from both their male counterparts as well as indigenous workers and suggests, therefore, that their position represents "a sexually and racially categorised class fraction" (page 106, 1983).

Historically, there is continuity within discourses on immigration, in the construction of the immigrant population as a social problem. The socio-political response to immigrants is characterised by a number of key themes that emphasise threat and the erosion of national identity. As previously discussed, the large influx of Jewish immigrants toward the end of the nineteenth century led to restrictive legislation that defined citizenship in an exclusive and bounded way. The wider social context was characterised by a hostile response that constructed the Anglo-Jewish population as 'other'. The influx of African-Caribbean workers in the post-war period met with comparable hostility, epitomised by Enoch Powell's 'Rivers of Blood' speech in April 1968. This, despite the fact that Commonwealth nationals were directly courted, by the British Government, in order to meet a shortfall in the expanding transport and health sectors.

The British Nationality Act (1948) gave Commonwealth countries special immigration status, Commonwealth citizens and their families were given the right to enter and settle in the UK. This was prompted by the need for cheap labour, not least within a nascent National Health Service. Culley et al (1999) note that there was an estimated shortfall of 54,000 nurses in 1949 and this applied particularly to jobs involving long hours and shift work. African-Caribbean workers, especially women, were concentrated within nursing



and health care employment with a substantial number also filling ancillary posts within the health service.

Subsequent immigration has been characterised by a number of changes of countries supplying labour<sup>12</sup>. Between 1999 and 2000, almost three-quarters of the increase of the UK population was attributable to international migration (Summerfield et al 2003), a significant proportion of immigrant workers entering low-pay service sector jobs and areas of employment that have traditionally been hard to fill. Approximately a third of all inner London nurses are currently from overseas (Buchan 2000). The profile of care workers selected for the CPCEC project suggests that this proportion is higher within the independent care sector.

At present the health service's biggest provider of overseas nurses is the Philippines. According to UKCC figures for 2000, there was a 600% increase in the number of Filipino nurses applying to work in the UK. Migrant workers also enter the UK to train as nurses, however, restrictions upon their residency differentiates their experience from indigenous students.

"The continuation of their status as overseas students is always dependent on their satisfactory performance in whatever tasks are allotted to them, while after qualification they must obtain a job in order to remain in this country. They are therefore under considerable pressure to accept long hours, low pay and difficult working conditions that may well be compounded by racist attitudes from other staff and patients.' (Doyal, 1985, page 253)

In a study of Filipino migrant workers, Parrenas (2001) has highlighted the 'feminization of the international labour force' as a result of the targeting of women to fill low paid service work in many developed nations. Parrenas argues that such migrants acquire only partial citizenship in their host countries and throughout Europe, Asia and the Middle East, are segregated in low-wage service work. The study highlights the exploitative

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<sup>12</sup> However, the socio-political discourse framing immigration, continued to centre upon common themes. In 1978, Margaret Thatcher, as Prime Minister, referred to the country being 'swamped', following riots in Wolverhampton. More recently (April 2002), the Home Secretary, David Blunkett, was widely criticised for suggesting that local schools were being 'swamped' by non-English speaking immigrant students.



relations between comparatively affluent host countries and the nations from which they derive labour.

"By restricting the incorporation of migrants, receiving nations can secure their economies a supply of low-wage workers who can easily be repatriated if the economy slows down." (Page 1134, 2001)

Through emigrant workers developing countries generate foreign currency in order to offset the interest payable on the national debt. With remittances from migrant workers representing the single biggest source of such income for the Philippines. A recent article in the Nursing Times (Munro et al 2001) estimated that Filipino workers send 50% of their disposable income back home and this highlights the manner in which the familial and network responsibilities of these workers extend across national boundaries as well as motivating them to work abroad.

'Race':

UK employment statistics highlight that Black and minority ethnic groups fare differently within the employment market in comparison to white groups. Ethnic minority groups are more likely to be unemployed than the white group, across all ages (Summerfield & Babb 2003) but differences also exist between these groups. Within-group differences according to gender are also apparent across all groups. Unemployment statistics for Black and minority ethnic communities also highlight their greater vulnerability within the employment market during periods of high unemployment (Sly 1994).

With regard to informal care, Atkin and Rollings (1992) note that there has been limited attention to Black and minority ethnic communities with the result that much of the understanding of inequalities in care fails to encompass 'race' and ethnicity. Within formal care, women from all ethnic groups are more likely than men to work in the health sector. A study of Black nurses by Baxter (1988) has highlighted a number of structural factors that differentiate the experiences of Black from white nurses. This includes recruitment disadvantages and deployment; with many Black nurses concentrated in the least



rewarding and menial jobs, and their concentration in unpopular specialisms, and night duty posts. Baxter also recorded differing experiences and prospects of promotion.

These findings highlight the differentiated experience that Black and minority ethnic workers have in the employment market and the manner in which this interacts with gender. In addition to being concentrated in certain fields of employment, ethnic minority and immigrant women also face a differentiated working experience, an issue that was highlighted by data from the CPCEC study.

Of the 32 care staff and six non-care staff recruited to the project the breakdown, according to ethnicity was: 19 (50%) Black staff, including Black British, African and African-Caribbean, 14 (37%) white staff and five (13%) Asian staff, four of whom were Filipino. Jewish Care communicates with all its workers through a staff newsletter, entitled 'In Focus'. The Winter 2000 edition reported the results of a staff survey on communication, which received a 17% response rate from staff. One of the main issues raised by the in-house survey was the finding that respondents had "concerns about treatment of black staff by people in contact with Jewish Care. In response to this feedback 'In Focus' reported that 'a cross-organisational working party was to be set up under the auspices of the Chief Executive'. With regard to racism, the In Focus magazine reported:

"Many staff mentioned they had experienced racist remarks, rudeness or other forms of discriminatory behaviour from some clients, relatives, volunteers and lay people. Although most staff are more understanding and tolerant of this kind of behaviour from elderly clients, they do not feel they should accept it from relatives and others" (In Focus Summer 2001).

During interview, a third of white staff (n. = 4) and a quarter of ethnic minority staff (n. = 5) made particular reference to occasions when residents were racist toward staff. There was some variation in how the impact of such experiences was evaluated by respondents. Also, differences in how residents' racism was accounted for, with some respondents emphasising the onset of dementia as an influence upon racist outbursts.



"There's a lot more black staff here than white staff and the residents can be very rude to them sometimes, but the staff don't take any notice, they really don't, you know.' ... 'We've got a lady out there now, not always, but sometimes if the staff are in the room and they are changing her and you can hear her scream and scream and screaming and when I go in there she goes 'oh it's you dear, thank goodness'. So they are a bit like that you know". (rhcc24(f))

- "I don't know why, but they are racist and they often call them 'blackies' or 'I won't have that black person' you know, I've come across that and also I've been told by staff that why I am doing a certain resident is because I'm white, so that racism does come into it."
- "And how do you overcome situations like that?"
- "Well, they get upset but then I go and do the resident and then you know, but you can't really tell someone who's got dementia that they're doing wrong, because it's how they feel, they've been brought up like it." (rhfc23(f))

"Sometimes, the residents with Alzheimer's, they say what they want as compared to a sensible person. They will say what they think 'you're black' or 'you're brown'. ... 'I do nothing, it wouldn't make an impact on them. You mustn't say that you are racist, it wouldn't make much difference, especially this generation of people you know, some of these haven't seen a foreign nurse in their life". (rhec11(f))

"If I can avoid, I will avoid, some people are very rude here and they are very rude sometimes the way they talk to you, mention the colour and call where you come from. They call me Paki (laughs).' ... 'This gentleman he calls me 'Paki pig' (laughs), Indian pig, I mean I am not from India but he call me Indian pig and the man told me, 'how dare you come from Paki' that's not only me, quite a few people, yeh." (rhec9(f))

These responses highlight a number of issues with regard to relations within care homes. At times, ethnic minority staff are singled out for differing, and often negative, treatment by residents. The responses also highlighted that such experiences represented a significant area of emotional labour for some ethnic minority carers, many of whom found challenging racist attitudes difficult and were unsure of the benefit of doing this with people with dementia.

"I try my best or you do all that and you open the door to come for the breakfast, immediately he just get up with this 'bastard, black bastards', that is the word he says for thank you. I don't know how people they handle it, but me, I am a tearful lady, it really does pain me." (rhbc6(f))



"If they behave racist, it's not like, you can't sort of not give them the care if they are going to behave racist towards you, but at the same time, the special attention, they may not get that.' ... 'I don't dwell on the stressful things and what have you, I try to uplift myself, otherwise, when I get home, I'm going to be very nasty to my daughter". (rhec18(f))

A number of respondents noted racism and/or differentiated working experiences for ethnic minority workers at an organisational level. There was also some indication that appropriate or adequate support or preparation for staff experiencing racism at work was lacking.

- "All we can tell them is not to say those things. But I think when you come for your interview, they sort of tell you about how do you feel about working with ethnic minorities, but they never sort of sit down and tell you 'how do you think you'd deal with it?' If one of the residents turned around and he was quite racist towards you, they never sort of tell you those sort of sides of it, which I think is a shame. I think there should be, I don't know, maybe a course to go on about how to deal with, or how to address a resident if that happens, but as far as I know there's not".

- "Are there any courses that cover that along with other challenging behaviour?"

- "There are courses which learn about challenging behaviour, but I just think a lot of staff here have to put up with a lot of racist comments, and they don't, as far as I know, there's no course. It would just be nice if there was, you know, in the interview, it was addressed to them, about how they could deal with it or how they could talk back, not talk back but, you know, how to calm residents, or how to answer if they were like that". (rhec14(f))

"They suffer this memory loss and they can only remember in their early years, where, you know, they didn't like black people and see a non-Jewish person as, you know, they sort of build up this fear.' ... 'I think we need training to deal with stressful situations better. Because sometimes it's very stressful, very, and it's irritating as well, being called 'black, bitch, bastard'." (rhec18(f))

"Since I've been working here (laughs) I can remember that my intonation and my accent, they will try to make some of us from Africa to change it, but I was one of them that didn't want to change my accent." ... "In this home, I was the only coloured nurse, I will call myself coloured nurse, for four years and when I first came I could see the relationship is not there, but I just come in to do my job and go. And those that are working with me when I first came, they had got some coloured people here before but they left because of their attitude towards them." (rhlc32(f))



"I will go to her, but she doesn't like me. If I go there she starts screaming and you know, even if I didn't (do) something to her, she will say to me 'ehhh, (name) was here and just beat me up'. She will start screaming and they are doing this many times, they are doing this to my colleagues and some of them they get suspended for nothing, because they didn't take notice to us, whatever they say they believe, they don't believe us, mmm". (rhec27(f))

Attention to 'race' and ethnicity has highlighted a differentiated experience for Black and minority ethnic care workers. Residential dementia care has been shown to be both a gendered and racialised field of employment, serving to problematise a unified concept of 'woman' underpinning much of the debate on care. It is clear that 'race', gender, class and immigrant status interact at a number of levels, structuring women's relation to both formal and informal care provision. The promotion of formal care as a 'solution' to the exploitative relations underpinning informal care may therefore be understood to be limited by a focus of attention on gender, without a developed understanding of how gender interacts with other axes of power.

Within the context of the UK employment market and at a wider, global level, exploitative relations shape employment for particular groups of women. As such, there is a need to place the debate on care within this wider network of relations, including the imbalance of power between developed and developing nations. Not least in regard to care, there is a need to pay specific attention to the experiences of migrant women. Network caring responsibilities motivate the search for work overseas with the maintenance of these responsibilities, over distance, a decisive factor underpinning overseas employment. The profile and experiences of the cohort selected for the present study supports Phizacklea's (1983) assertion that migrant women's position in the employment market represents a 'sexually and racially categorised class fraction'. 'Race', gender and class 'connect' to constrain employment choice and opportunities and this is evidenced by the demographic specificity of the work force in this type of care.

An important aspect of the differentiated experience of ethnic minority workers is the impact such experiences may be understood to have upon caring relationships. The data



for the present study gives a clear indication that some residents position Black workers as 'other', not least through racist abuse. This is a key consideration in regard to claims that a divide between informal and formal care represents a 'false dichotomy'. For Black carers, the social distance that underpins their experiences of racism, points to a particularly significant feature of 'care for others', differentiating it from network care. Residents' racism also highlights the importance of understanding care relationally, as a joint construct of the provider and recipient.

Recipient/provider:

Another contested dichotomy emerging from the debate on care is that of recipient/provider. As previously noted, much of the discussion of care, as a field of social activity, has been premised upon attention to family care provided by women. As such, Morris (1991, 1993, 1997) has argued that an implicit hierarchy of identities underpins this debate, in which:

"The language that was used clearly identified the interests of the feminist academic with the interests of the woman carer whilst there was no similar identification with the interests of older and disabled people. In the process not only were disabled and older people constructed as dependent people but the category, women, was constructed as non-disabled and non-elderly." (Page 363, 1997)

The perspectives and interests of the recipients of care have received far less consideration and are less well accounted for in the growing body of research on care. Research into the care of people with dementia provides a particularly clear example of this imbalance, with many studies relying upon 'proxy' accounts given by both formal and informal care providers. Such an imbalance may, in part, stem from the communicative impairments that characterise the experience of dementia and the inadequacy of traditional research methodology to overcome this. However, a comparable imbalance has been identified within the present study in relation to care practice.



With regard to the regime within residential dementia care, analysis of care plans and files revealed an absence of direct input from residents themselves, often attributed to their condition:

'Views of Resident: Mrs X sadly unable to express her views due to her mental state.' (Placement review for RH15(f))

'Charming man, he discourses in a long and involved way and is talking total rubbish.' (Social Services assessment for RH12(m))

This points clearly to conditions under which the subjective experiences of care recipients are rarely being utilised to inform care provision. Such conditions may serve to explain why the priorities and perspectives of residents have been frequently viewed as marginalised within care settings.

"In most cases of persons diagnosed as having dementia, their social interactions do not allow them to maintain a sense of themselves as lovers, helpers, carers, teachers or whatever. It is not simply that there is no place for them to perform, even marginally, in these roles but that there is no place or permission for them to talk about themselves as occupying these roles." (Bender and Cheston, 1997, page 523)

More recently there has been growing attention given to the perspective of the person with dementia and recognition that proxy accounts are often an inadequate means by which to evaluate care. A study by Barnett (2000) highlighted this issue:

"Staff saw carers as the nearest approximation to the voice of the client, and managers saw staff in the same way. Yet limited by their own positions, neither staff nor family carers could speak for anyone but themselves." (Page 209/10, 2000)

Triangulation of data for the CPCEC project underscored this point, revealing considerable dissonance between the perspectives and evaluation of care by formal and informal carers as compared to video data and responses elicited from people with dementia themselves. Attention to the perspectives of people with dementia and their experiences of care has therefore sought to identify a workable means of overcoming the



limits of traditional research methodology (Goldsmith 1996, Barnett 2000, Allan 2001 and Wilkinson 2002). However, in re-dressing the imbalance of existing research such studies arguably perpetuate a bifurcated model of care.

"Traditionally, care research has focused on eliciting the perspective of either carer or caree' ... 'This has resulted in (re)producing a dichotomy between carers and carees (and reifying differences between the two groups) as well as creating two bodies of literature - one pertaining to care-givers, one pertaining to care-receivers." (Forbat, 2003, page 68)

Studies paying attention to the interactions between care providers and receivers (Hanson 1994a, Forbat 2003), have highlighted the extent to which caring relationships are co-constructed and the manner in which this is framed by an imbalance of power. It has been made clear that attention needs to be paid to what each member of the caring dyad contributes to the relationship. The present study has revealed a wide variety of approaches to care indicated by care workers. It is therefore reasonable to suggest that a similar diversity may apply to those in receipt of care. The racism noted by care workers in relation to their interactions with some residents demonstrates that the quality of caring relationships is also shaped by the attitudes of residents and the positioning of care workers as 'other' according to factors such as 'race'. It therefore cannot be assumed that the recipients of care uniformly share a consistent approach to the caring relationships of which they are a part. To date, little attention has been paid to variance between caring relationships, or to what factors underpin this. Nolan et al (1995) point out that few published studies have addressed the social politics of the care environment, investigating why and how some residents receive a disproportionate share of carers' attention and communicative input.

Care workers interviewed for the CPCEC study, highlighted the manner in which their relationships varied across the client group. Interviewees were asked whether they had better relationships with some residents, compared to others and, if so, to suggest reasons why this might be. Of the 29 responses to this question (n.3 = information missing), eight (28%) carers reported that they viewed and treated all residents as equal and did not therefore have better relations with some residents than with others. However, 21 (72%)



indicated that they enjoyed better relationships with certain residents, a variety of reasons were offered as to why this was the case. A large proportion of carers reported having better relationships with residents who communicated in a friendly manner, while a number of carers mentioned disruptive or aggressive conduct as a reason for having poorer relations with certain residents.

"I wouldn't like somebody who's loud or aggressive or too abusive, it doesn't appeal to me, but I would try to communicate anyway. I prefer somebody who's calm". (rhbc20(f))

"Oh yes, because they are not aggressive, they are not abusive, all their words are kind, you know, kind words and there are some ladies who are really grateful.' ... 'Sometimes she can't talk but she will try to show that she is really grateful for what you are doing for her. So whenever you go, you know, you feel like you love that lady, you must when somebody is grateful for what you are doing". (rhbc6(f))

Positive and negative input from residents therefore appears to influence the relationships between care provider and receiver. This evidence suggests that the conceptualisation of care, based upon attention to the care provider, is inadequate to account for how meaning is attached to care at the level of direct interaction. Another outcome of addressing care relationally, is the manner in which this highlights a two-way flow between the traditionally polarised input of provider and recipient.

With regard to network care, Arber and Ginn (1997) have drawn attention to the reciprocity that underpins much care of older people: "Caring is generally only one part of a complex dynamic of reciprocity" (page 348, 1997). Finch (1989) has argued that reciprocity needs to be understood as unfolding over time, creating commitments between individuals throughout the course of their relationship, also within the context of a familial network in which support to one individual may be indirectly 'repaid' from one part of a family to another. These patterns of support are gendered but also shaped by factors such as culture and ethnicity.

Within formal care settings evidence has been offered to suggest that the input and contribution of care receivers is overlooked by care providers (Berg et al 1998), also that



care between residents is often curtailed in the presence of care workers (Sandman and Norberg 1988). Such findings point to the input of care workers as 'positioning' residents as recipients of care, with a variety of residents' skills and capacities remaining latent through over-accommodation. The dichotomy of provider/recipient therefore masks the complexities of the caring relationship, promoting parallel debates on care as something that is either given or received. Furthermore, with regard to care for others, the indirect but authoritative input of the wider regime that mediates the caring relationship appears to be a crucial consideration. As such, the outcomes for each party cannot be considered in isolation from the combined contribution of all.

## CONCLUSION:

Exposing the patriarchal benefit derived from an association of femininity with care may be understood as a cornerstone of the feminist politicisation of care. A concern with this underpinning, gendered inequality has led to gender being centrally located in the appraisal of care in society. Thus, gender may be understood to 'organise' much of the debate on care. However, it has been argued that the manner in which care may serve to organise an understanding of gender has been less well explored.

While recognising the significant outcomes associated with an interaction of network care with formal caring activity it has been argued that there are a variety of distinct forms of care. Clear benefits are associated with recognising the distinguishing attributes and relations that underpin each. Within care for others, it has been argued that social proximity between provider and recipient cannot be assumed and, indeed, that an absence of such proximity may be understood as a frequent, if not defining feature of such care. Nor can the dominant input of third-party 'brokers' and the institutional interests they represent, be ignored in how they structure caring relationships.

Attempts to engender differing models of care have been questioned. Considerable variation was noted within a largely female sample of carers, with regard to the models of care reported as underpinning their work. The finding of such within-group diversity



serves to undermine arguments that gender 'explains' how care is provided, or how meanings are attached to caring relationships. The presence of men within formal care, alongside what they do as carers, appears shaped by the dynamics of the care setting alongside a wider gendering of care; raising the question of the extent to which approaches to care are chosen or imposed. Thus, masculinity appears to interact with care, with some male and female carers employing gendered narratives to differentiate masculine and feminine caring.

It has been argued that emphasis upon commonality has served to mask arguably crucial differences and divisions between women. As such, a hierarchy of identities has been shown to exist within both the conceptualisation, and social practice, of care. The particular attention given to the provider's perspective within explorations of network care has created a hierarchy in which the perspectives of some women appear less well considered and accounted for within the debate on care, than others. Yet, the interaction of factors such as class, 'race' and immigrant status clearly position women differently in relation to both paid and unpaid care. Within the debate on care, the isolation of gender as a primary form of social organisation has attenuated a more complex understanding of how gender 'connects'.



## 7. INTERACTIONS - INTRODUCTORY ANALYSES

### Introduction:

Having explored gender in relation to a hierarchy of identities in care, consideration will now turn to the dynamics of care, in particular the interactional dimension of gender as part of this. Representative examples of the everyday interactions of care home settings will be considered in detail to explore the presence and functions of gender as an organising presence upon social relations.

As an introductory to this section of the study, two pieces of analysis were undertaken with the aim of providing a 'communicative context' to the ensuing discussion<sup>13</sup>. Both analyses sample the video data generated for the residential care phase of the CPCEC. In the first analysis the overall characteristics of the communication between care workers and residents are highlighted. In the second analysis a case study format is employed to compare the communicative experiences of two mixed-sex pairs of residents. Coding schedules<sup>14</sup> (Appendices 6 & 7) were composed specifically for the study and were designed to focus the analysis upon factors including the nature of the interactions, their frequency, duration and content. Particular attention was paid to carer-initiated interactions within both analyses.

### Analysis 1: Communication

As part of the CPCEC project, a total of seventeen residents were filmed in the communal dayrooms of eight units in five care homes. Each resident was filmed for four and a half

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<sup>13</sup> This analysis was carried out within the context of the wider project 'Dementia of the Alzheimer's Type: Communication Patterns and their Consequences for Effective Care' (Vass et al 1998). The wider focus upon interaction and communication between staff and residents provides the context within which gender relations are to be investigated, but constitutes the domain of the wider investigation. This introductory analysis and the resultant findings thereby fall within the remit of the wider project and are to be considered as touching upon the issues addressed in greater depth and detail by it.

<sup>14</sup> Coding schedules were developed specifically for the purpose of the study and therefore not previously tested or validated in any other contexts.



days (finishing early on Fridays due to Sabbath). Filming took place between 7am and 7pm and each videotape lasted up to 4 hours with the day therefore divided into three sections; 7am-11am, 11am-3pm and 3pm-7pm. This generated approximately 230 tapes (excluding pilot tapes). From this body of data at least 3 tapes per care unit were selected, ensuring that each section of the day was covered and each project participant was represented in at least one of the tapes. In all, 30 tapes, with over 100-hours worth of footage, were scanned using event sampling to note and time each discrete interactional episode.

#### The environment and communication:

In all eight units, seats were arranged in rows mainly backed up against the wall. This clearly inhibited resident-to-resident interaction. Where seats faced one another, the size of the thoroughfare between them, designed to allow free passage of wheelchairs, proved a further obstacle to interaction. On some units, background noise was also a factor that inhibited communication. Television or radio volumes were often high and in larger open-plan units acoustics were poor.

#### Definitions and classifications:

Each interactional episode was classified according to three categories:

- 1.) 'Task-based' - those interactions where the focus of communication was upon the completion of a care task.
- 2.) 'Social and/or relationship orientated' - where relationships or social issues were the topics of communication, and/or there was a focus upon social engagement between residents and care workers or an attention to the identities and 'inner worlds' of residents or their relationships with others.



- 3.) 'Combination' - where task-based episodes of interaction were observed to include social and/or relationship oriented communication.

It is important to acknowledge the difficulties of ascribing what meaning a particular interactional episode may have for both a carer and resident as judged by an external observer. Classification was based primarily upon the spoken content of the interactions in conjunction with the non-verbal activity accompanying it. However, as a non-participant observer, a variety of constraints exist in reading a carer-resident interaction. Defining an encounter as specifically 'task-based' risks overlooking the associative and relationship-building qualities that such care involves. For example, the 'task' of assisting someone to eat may also enhance and be an expression of the bond or rapport between carer and resident, acting as a symbol or a signifier of the relationship for both.

For the purposes of the analysis an 'interactional episode' was defined as any encounter, verbal, non-verbal or both which involved a resident. In the event that a resident was approached, left and then returned to, this was classed as two separate episodes. Using the videotape change-over times to divide the day into three 4-hour periods (7-11, 11-3 and 3-7) each period was analysed within each unit. An average number of interactional episodes were then calculated for each period of the day and on an overall basis. While each tape ran for 4 hours, the residents were present within the day-room area for varied lengths of time. The average period for actual analysis was 2 hours 50 minutes per tape.

A proportion of interactions, especially those with care staff, were fleeting, i.e. a brief greeting or handing over a cup or plate. These momentary encounters were classed as 'snap-shot' interactions and, for the purposes of the analysis, were rounded up to a duration of 5 seconds.



Table 1. - Averages of interactional episodes with residents across all 8 units:

	Period 1	Period 2	Period 3	Over day-12 hrs
Average number of all interactional episodes	11.3	11.8	12.7	35.8
Of which; with researcher	1.6	0.9	1.4	3.9
With 'others'	2.9	6.2	4.7	13.8
With carers	6.7	4.4	6.6	17.7

Table 1. The frequency of interactions for people with dementia are low. This first table shows the average number of discrete interactional episodes occurring for each four-hour period and across a full day (i.e. 12 hour period). It shows that the majority of interactions for people with dementia are with carers.

Table 2. Averages of interactions with carers:

	Period 1	Period 2	Period 3	Overall
Average number of interactional episodes initiated by carers	5	3.4	4.5	12.9
Of which; number of task based	3.5	2.3	4.1	9.9
Number of social/relationship	1.1	0.7	0.2	2
Number of 'combined' episodes	0.4	0.4	0.2	1
	Period 1	Period 2	Period 3	Overall
Number of snap-shot	1.1	0.5	1.5	3.1
Number of wholly silent contacts	0.6	0.8	0.9	2.3

Table 2. A large portion of the interactions between care workers and residents are task-based. This table highlights the interactions initiated by care workers and shows the average number of episodes occurring within each four-hour tape and across a 12-hour period. Episodes of interaction labelled 'task-based' were of the most frequent type occurring during each four-hour period.



Table 3. Timings:

(m = minutes, s = seconds)

	Period 1	Period 2	Period 3	Average of the 3 periods	Average across 12 hours
Duration of all interactional episodes	17m - 15s	15m - 30s	41m - 30s	24m - 45s	74m - 15s
Duration of carer initiated episodes	6m - 20s	7m - 30s	4m - 45s	6m - 10s	18m - 35s
Total duration of verbal interaction in carer initiated episodes	3m	2m - 50s	1m	2m - 20s	6m - 50s

Table 3. Duration of interactions is short and verbal content is limited. This table shows that throughout the day, the actual contact time between residents and care workers is limited. Furthermore, when such contact takes place there is limited verbal communication as part of each episode.

Table 4. Encounters with care workers according to gender:

	Period 1	Period 2	Period 3	Overall
Carer gender (% across all interactional episodes)				
Male	6.5%	23.5%	24%	18%
Female	93.5%	76.5%	76%	82%

Table 4. For both male and female residents, the large portion of interaction is with female care workers. This table confirms that as a consequence of there being a predominance of women as care workers in each home, residents interact with female carers far more often than with male carers.

Discussion

Interaction not involving carers:



In addition to the exceptional interaction with the project researchers, residents had contact on a more on-going basis with volunteers, relatives, domestic staff, catering staff, activity co-ordinators, various in-house and external therapists, health and social care professionals, religious figures and, most frequently, with one another. These interactions accounted for nearly half of the day-to-day contacts for residents.

Interaction with non-care staff appeared qualitatively different in content to much of the contact with carers. Volunteers and relatives were less often engaged in task-based activity, consequently the content of their interactions with residents seemed more socially oriented. Residents were also observed assisting one another. However, interaction was by no means consistently positive or supportive. On occasions, residents with dementia were observed being treated in a stigmatising manner by others (for example being shouted at or waved away), or wholly excluded from interaction with other residents.

#### Day-to-day interaction:

The above tables provide an interactional ‘map’ for people with dementia residing in Jewish Care facilities. The statistics were averaged out across eight separate units and included people with varying degrees of (observed) communicative difficulties. Some notable issues to arise from the analysis are:

- The overall low level of communication experienced by people with dementia living in care.
- The low levels of social, identity and relationship-oriented communication between staff and residents
- Consequently, the highly restricted opportunities that residents have for social engagement.

The present analysis revealed that interaction, over a 12-hour period, within a dayroom context, took up 10% of the day, with 2.5% of the day spent in carer-initiated interaction. Comparable research into levels of engagement and activity (discussed earlier) support



these findings (Hallberg et al 1990, Bowie and Mountain 1993, Gilloran 1993 and Nolan et al 1995). This consensus of findings points to the likelihood that the Jewish Care homes under scrutiny are representative of the wider experience of care for older people with dementia on both a national and international basis. The brevity of much interaction with carers is compounded by its largely task-based content: 78% of all carer-initiated contact.

The erosion of social relationships:

Constituting over 50% of all interactional episodes for residents, the most consistent, on-going and frequent encounters are those with care staff. However, the analysis shows that only 16% of carer-initiated interactions with residents were of a purely social and/or relationship-building nature. Whilst it is possible that workload pressures inhibit prolonged social interaction between care staff and residents, it seems that existing opportunities for such engagement were demonstrably under-utilised. Only 7% of carer-initiated contact combined the completion of a care task with some form of social engagement. Furthermore, approximately only one third of the contact time between care staff and residents involved verbal exchanges. The extent of silent care seems to indicate an absence of a social relationship between staff and residents.

#### Analysis 2: Gender and communication

Having demonstrated that only limited social interaction takes place between carers and residents with dementia, attention will now be paid to the influence of gender upon interaction between staff and residents. Of the limited existing research addressing the social factors influencing interaction between care home residents with dementia and their carers, Lindesay and Skea (1997) found that gender influenced levels of interaction with a number of outcomes.

- Male residents initiated more interactions with staff than did female residents.
- Female residents did not initiate any interactions with male staff
- Female staff initiated more interactions with residents than did male staff.



- Both male and female staff initiated a higher proportion of interactions with male residents than with female residents.

These findings suggest that male residents receive greater input despite being in the minority within a residential care home environment and point to gender as an unrecognised but organising factor in the provision of care to people with dementia, with a potentially negative outcome for female residents. The findings also correspond with existing arguments that a gendered hierarchy is both expressed and upheld through men's (and boy's) dominance of conversation and interaction (Uchida 1998).

A problem in the comparative study of men and women, in any given context, is the difficulty in defining exactly what is being compared. To what extent can gender be considered a discrete variable and thereby compared in distinction from other social factors such as class, ethnicity and age? Within the Lindesay and Skea study, levels of communication were measured with no attempt made to control for intervening variables such as the possible influence of levels of perceived need and dependency. As such, an underlying hypothesis for the present analysis was that any attempt to measure levels of communication in a setting where contact is associated with the input of care tasks necessarily requires attention to variation in levels of (perceived) dependency.

#### Aims and approach:

In order to carry out a comparative study of levels and type of interactions according to gender, a case study format was used. Analysis of videotaped data focussed upon each interaction between staff and four residents over a period of three days per resident. Each interactional episode represented a unit of analysis. In order to incorporate a consideration of any gendered differences, two men were matched with two women.

The study compared interactions between staff and residents within two nursing homes. Focussing upon four case studies (one man and one woman from each of the two homes). The two mixed pairs of residents were 'matched' according to observed levels of physical



dependency and mobility. The sample group were not tested for cognitive capacity but observed as they functioned in the natural day-to-day surroundings of the care homes in which they reside. On the basis of this observation an attempt was made to match each pair according to their communicative contribution to episodes of care.

#### Sample profiles:

F(female)1 and M(male)1: the first pair of participants were resident in different units of the same nursing home belonging to Jewish Care. F1 spent her day in a large open-plan unit on the ground floor of the home. The staff were predominantly female but with some male carers on some shifts. The resident population was comprised of twenty women and four men. M1 resided in the smaller dementia care unit on the top floor of the building. The composition of the staff group in this unit was almost exclusively female while the client group was comprised of four women and seven men.

F1 - Health on admission: high blood pressure, arthritis, gout and dementia.

Date of birth: 7/1/13

Date of admission: May 1998

On the occasions when care workers spoke to F1 and sought a response from her, she was observed to respond appropriately. Occasionally she observed to initiate interactions with staff or residents. F1 was wheelchair-bound and required the assistance of two carers when transferring from her wheelchair to a seat. She would eat unassisted but was observed being regularly prompted by carers to finish her meal.

M1 - Health on admission: recurrent U.T. I., asthma, cellulitis and Alzheimer's.

Date of birth: 13/8/18

Date of admission: June 1999

M1 was observed responding appropriately when care workers spoke to him and sought a response, but rarely initiated interactions with staff or other residents. He was immobile and cared for in a 'tub' chair. M1 required the assistance of two carers to transfer and of one carer during mealtimes.



F2 and M2: Both these subjects resided on the same dementia care unit of the largest of Jewish Care's residential homes. The purpose-built unit formed part of the largest of Jewish Care's homes. The unit housed 16 men and 24 women, with a mixed staff group with women in the majority, however male carers were present for most day shifts during the period of analysis

F2: Health on admission: Alzheimer's and cerebral ischaemic attacks.

Date of birth: 14/01/12

Date of admission: October 1996

F2 was rarely observed to respond verbally when carers spoke to her and sought a response. She used few facial expressions but would on occasion respond with a smile or surprise carers with a one-word response to their questions. She was observed using few gestures or hand movements and appeared to have limited head and body movement. She required the assistance of two carers for transferring and the assistance of one carer at mealtimes.

M2: Health on admission: Early onset dementia, diagnosis of Alzheimer's in 1984.

Date of birth: 23/02/36

Date of admission: April 1999

M2 was not observed to respond verbally however, he would sometimes make sounds in response to carers' questions and smile. He was observed using few facial expressions, gestures or hand movements. Physically he appeared stiff and unable to turn his head or body. M2 required the assistance of two carers to transfer and of one carer during mealtimes.

Data gathering and analysis:

Filming of project participants for the CPCEC project generated approximately 14 tapes per person, of these tapes the first day of filming was excluded to lessen any potential 'Hawthorne effect' from the presence of the cameras and researchers within the Unit. The



film of the last half-day was also excluded to leave three full days worth of film for each subject<sup>15</sup>. A coding schedule was developed to focus upon differing aspects of the interaction, timings for each encounter and space for notes and to keep a record of spoken content.

#### Day-room interaction:

To protect privacy, cameras were restricted to communal areas, the analysis was therefore largely restricted to the periods when residents were present within the day-room area. For all participants this represented a large proportion of the day. Mealtimes were also included in the analysis. None of the four subjects were independently mobile and required assistance in transferring to a wheelchair to move around the home. As such, all four tended to remain in the same place throughout the day, being moved only to sit at the dining tables during mealtimes and when assisted to use the toilet. M1, who resided in a small open-plan unit was assisted to eat where he sat throughout the day and was not brought to the dining table.

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<sup>15</sup> This process of selection was formulated and proposed for the wider investigation (Vass et al 1998).



Table 1. Analysis duration and total frequencies of interactions

	F1	M1	F2	M2	
Total period of analysis (TPA)					
Day 1	10h 38m	10 h 54m	8h 15m	8h 49m	
Day 2	8h 01m	9h 11m	7h 00m	9h 05m	
Day3	10h 54m	3h 56m	6h 42m	7h 25m	
Overall	29h 33m	24h 01m	21h 57m	25h 19m	
Total no. of ints. (excl. rschr.)	117	40	36	50	
Total res-res. ints.	20	4	4	7	
Total of interactions w/ 'others'	7	6	0	4	
					Mean %
Total of carer-init'd interactions (as %age of all ints.)	89 (76%)	30 (75%)	32 (89%)	39 (78%)	79.5
Of which:					
Snap-shot	20 (22%)	1 (3%)	4 (12%)	2 (5%)	10
Task-based	74 (83%)	23 (77%)	26 (81%)	31 (79%)	80
Social/relnshp.	6 (7%)	5 (17%)	5 (16%)	3 (8%)	12
Combined	9 (10%)	2 (7%)	1 (3%)	5 (13%)	8

(ints. = interactions, res. = resident, h = hours, m = minutes)

Table 1: Low levels of socially oriented engagement in comparison to care task completion for all participants. This table provides interaction frequencies for each resident and a breakdown of the nature of each interaction. During filming across three days, each subject was present before the camera for differing periods of time. This led to the issue of how to standardise the data across the sample in order to draw comparisons and judge any variation. It was decided to retain the naturally occurring periods of analysis for each participant, despite their differing duration and to percentage the figures in order to standardise them as proportions of the overall period of analysis. The percentages given therefore provide a better aid to comparison than the actual frequency count. A large proportion of the interactional encounters experienced by each resident was with a carer. The table also confirms the previous finding that a large proportion of carer-initiated



interactions were task-based (mean of 80%). This statistic provides a context for considering the limited opportunities available to a resident during which a social identity may be expressed or negotiated in interaction with staff.

Intervening variables for interactional frequency:

Visitors: The presence of a visitor proved an influence upon the frequency and duration of carer-initiated interactions. The presence of visitors was observed to reduce carer input and seemed to act as a barrier between carers and residents with care staff often observed focussing their attention upon the visitor. During the period of analysis, M2 was visited by his wife for a total of 6 hours 18 minutes and some activities (such as assisting M2 to eat), which may have been carried out by the staff, were undertaken by his wife.

Context: The frequency of resident to resident interactions was higher for F1. This may have been due to her residing in the larger and more populated context of the main day lounge of the home. The overall number of residents was greater than on M1's unit, potentially offering more opportunities for interaction.

Dependency: F1 has a proportionally higher frequency of carer-initiated interactions than the other subjects. However, an intervening variable when considering the figures (in Table 1, above) appeared to be the type of assistance each participant was deemed to require by care staff. In contrast to M1, F1 would eat unassisted but received frequent verbal prompts from staff while eating her meal. As such, she experienced a greater proportion of short-lived and often snap-shot interactions with staff as they prompted her to finish her meals. This is in contrast to M1, F2 and M2, all of whom had carers sitting with them during mealtimes, the pace at which they ate being more directly controlled by care workers as a result. This finding suggests that the nature of need and the level of dependency are key factors shaping patterns of interaction between carers and residents. This point is further supported when comparing the proportion of social/relationship oriented interactions (7%) and of combined interactions (10%) for F1 with the other participants, all of which are at a similar level (means of 12% and 8% respectively).



Table 2 - Duration of interaction

	Total period of analysis (TPA)	Total duration of interactions.	As % of TPA	Total duration of verbal content	As % of total intctn.	As % of TPA
F1	29h 33m	126m 15s	7	53m 35s	42	3
M1	24h 01m	124m 25s	9	17m 45s	14	1.2
F2	21h 57m	210m 15s	16	21m 35s	10	1.6
M2	25h 19m	178m	12	33m 05s	19	2.2

Table 2: Low levels of verbal content within the contact between staff and residents for all participants. This table reveals a disparity between the overall duration of interaction for each participant and the duration of verbal content within these encounters. The implication of these figures is that a large proportion of care is carried out in silence or with a very sparse use of conversation. This is consistent with the finding that most interaction is task-based, with much of the verbal input by carers observed to consist of brief instructional remarks or prompts to facilitate the performance of a care task. However, low levels of verbal content may belie a range of non-verbal strategies for communication, tailored to each resident and possibly difficult to discern through observation of video data.

The percentage of verbal content of interactions, as a proportion of the total period of analysis (ranging from 1.2% - 3%), supports a view of the nursing home environment as a task-oriented regime. Few explicit or structured opportunities appear to exist for socially-oriented communication. Indeed, it is difficult to discern how or where social interaction is manifest within such a sparse and limited verbal engagement between staff and residents. This is of particular concern given that interactions with carers represented a mean proportion of 79.5% of all interactions for the group, across a period of three days.

Table 2 also reveals a difference in the duration of interaction as a proportion of the total period of analysis between the two homes. The observed higher levels of dependency for M2 and F2 may account for the greater duration of interaction and contact with staff due



to the higher degree of input required in order to complete care tasks. Despite slight differences in the duration of interaction as a percentage of the total period of analysis between each paired subject, these differences are not consistent according to gender, suggesting that gender is not an influencing factor in the duration of carer-initiated interactions.

As a proportion of the total period of analysis for each resident there appears to be little difference between each pair regarding the overall duration of interactions. This would suggest that gender has limited influence upon the overall contact time between care workers and residents. However F1, for whom the proportion of verbal content within interactions with care staff was 42%, represented an interesting exception in Table 2. There are a number of possible reasons for this difference:

- Shorter interactions, of which F1 had a greater frequency, involve a higher proportion of verbal input.
- For F1, care tasks were completed through verbal prompting rather than on her behalf, by carers. This is consistent with, for example, F1 eating without assistance during mealtimes, but with the perceived requirement to repeatedly prompt her to finish her meal.
- A comparatively greater degree of independence as perceived by care staff, may elicit greater levels of verbal input by them.
- Finally, that F1 herself may have had a sustaining influence upon the verbal content of interactions with staff.

In contrast to the observed verbal input by M1, F1 made use of a variety of associative strategies during her contact with care staff, other residents and researchers, despite what seemed to be a difficulty in maintaining prolonged verbal exchanges. In contrast to M1, she used a greater level of overall politeness and was observed using compliments to care staff, researchers and others on 12 separate occasions over the three day period of analysis, this was frequently accompanied by gestures and other non-verbal enhancers, such as smiling and touch. Examples include:



Carer (female): (Stands in front of F1 and sings)  
F1: 'Oh you're wonderful you are' (smiles)  
Carer: 'Thank you (name), so are you' (smiles)

(As female carer passes)  
F1: 'How's my little girl? My lovely little daughter?'  
Carer: (approaches F1 and talks with her briefly, before moving on).

F1: 'Oh you lovely girl, you're a lovely girl now' (holds out hands to passing female volunteer and smiles)  
Volunteer: (approaches, holds hands briefly and moves on).

The general level of politeness used by F1 was greater than M1 and in contrast to the more instructional and sparse use of speech by carers. This one-sided use of politeness and of rapport-building conversational strategies by F1 can be understood firstly, as an expression of the imbalance of power that exists within the care environment. Secondly, it is suggestive of potentially gendered differences in the approaches to interaction by residents. Also of note here, in relation to the associative strategies employed by F1, is the response made by carers. These were characterised by a brief and limited acknowledgement followed by a verbal or non-verbal closure of the encounter, such as walking away or turning toward another resident or carer. Thus, the efficacy of these strategies is limited by the response they elicit from care staff.

Table 3 - Duration of social/relationship building and combined interaction

	Total duration of S/R int.	As % of TPA	Total duration of comb'd int.	As % of TPA	Total of S/R and comb'd	As % of TPA
F1	2m 20s	0.13	13m	0.7	15m 20s	0.9
M1	2m 10s	0.15	3m 25s	0.2	5m 35s	0.4
F2	1m 40s	0.12	11m 25s	0.9	13m 05s	1
M2	- 30s	0.03	16m 05s	1.1	16m 35s	1.1

(m = minutes, s = seconds)

Table 3: Socially oriented interaction constitutes a small proportion of the day for residents with dementia, irrespective of gender. This table draws out the carer-initiated



interaction which focussed upon social engagement and/or the relationship of the carer to the resident and that which was combined with a care task, (i.e. when a carer used the performance of a care task as an opportunity to engage a resident socially). These statistics, representing the measurement of interaction over a 3-day period for each participant, highlight the limits of the social interaction taking place within the institutionalised care environment. With a mean percentage of 0.1 social or relationship oriented interaction as a proportion of the total period of analysis, the marked paucity of interaction that is divorced from the completion of tasks reveals an overall absence of social engagement. When totalled with the 'combined' interaction figures the mean percentage is 0.85 of the total period of analysis, revealing that care tasks are rarely used as an opportunity for social engagement.

The comparative analysis fails to support Lindesay and Skea's (1997) finding that the duration of social interaction with carers favours male residents. There is some difference in duration of interaction both within and between each pair however, these differences are not consistent according to gender. Thus, Lindesay and Skea's findings, suggesting the possibility that wider power relations associated with gender are reflected in the dynamics of the care environment have not been borne out by the present study. Arguably, this could point to a more egalitarian regime, whereby women and men are accorded a comparable degree of attention and input. However, the statistics for the proportion of socially oriented and 'combined' interactions between staff and residents fail to support this explanation. Instead, very clearly, the picture that emerges of the day-to-day life of residents with dementia, is one that is almost wholly shaped by and focussed upon a narrowly defined routine of physical care and its associated tasks. On this basis, and despite the employment of associative interactional strategies by some residents, the care relationship appears to contain very limited social engagement. Residents were observed to spend a large portion of their day in silence and when engaged in encounters with care staff were positioned to submit to various care tasks through an instructional commentary. This commentary apparently functions to preclude a more personalised (and time-consuming?) content, and will be discussed in greater detail in the next chapter.



A feature of the present study was the attempt to control for intervening variables related to the level of dependency associated with each participant, on the basis that these may have an influence over the levels of interaction between staff and residents. While differentiation has been shown to exist between residents, this appeared largely to be accounted for by the level of input required for the completion of care tasks. This points firstly, to the possibility that the institutional care environment has certain attributes or structures that differentiate it from a wider social context. Secondly, that an outcome of these structures is to divest residents of their social identities. The analysis has therefore proved illustrative in demonstrating how such a regime impacts upon the social identity of the person with dementia, following admission.

## CONCLUSION:

The overall picture given by this analysis is that physical care appears to have the greatest influence upon the frequency and duration of carer-initiated interaction. The analysis concentrated upon the classification of carer-initiated input and revealed a culture of care dominated by attention to task and physical care. The analysis pointed to infrequent carer-resident interaction and the brevity of much of this contact. This has clear implications for residents requiring supportive input in response to the impact of Alzheimer's.

Given the low number of participants in the present analysis, caution is required regarding judgements as to the significance or reliability of the findings. A further qualification is the possibility that the type and level of carer-resident interaction may differ in contexts not covered by the present analysis. Thus, interaction within the more private setting of a resident's room may vary from the contact taking place in more open and/or public settings, such as the day room.

The study revealed proportionally low levels of socially-oriented interactions between staff and residents. Also, low overall levels of verbal input by staff when in contact with residents. However, in the comparative analysis some difference in the level of verbal input was demonstrated, between participants, and a number of hypotheses were proposed



to account for this. One possible explanation being that the differing approaches to interaction by male and female residents may sustain verbal exchanges with staff and this highlights the importance of considering the input of both parties to any episode of care.

The study failed to support the finding by Lindesay and Skea (1997), that male residents received higher levels of staff input than female residents. The current study revealed that the social identity of residents was neither referenced within these interactions nor found to be an influence upon them. An attempt was made to match participants according to their communicative contributions to episodes of care however this proved less successful. Perhaps unsurprisingly, the subsequent analysis suggested individual (perhaps gendered) differences in the contributions made by participants. However, the study revealed that such individual variation appeared to have limited influence upon the overall time that each resident was afforded by care workers on a day-to-day basis. Therefore, arguably the most significant finding of the comparative analysis was the absence of any measurable association between individual communicative differences and the level and type of support and input offered by care staff.

Overall, both these introductory analyses combine to highlight a regime of care structured according to the undertaking of physical care tasks and in which such tasks are the primary influence upon levels of contact between staff and residents. In a setting designed specifically to support people with cognitive and communicative impairment it would therefore appear that the quality and level of communication itself is rarely considered a need.



## 8. INTERACTIONS - PART ONE

### Introduction: Researching care

In this chapter, attention will be given to how methods for investigating care are productive of ways of knowing and understanding it as a social activity. As a review of network care for people with dementia indicated, a common feature of many studies of care is a reliance upon interviewing with care-givers. Through this an impression of the meanings applied to care and how it is experienced for this group has been developed. However, limited concern has been shown to explore the manner in which an interview serves as the opportunity for respondents to give a public account of themselves, in this instance, as carers. Qualitative interviews employing open-ended questions offer the opportunity for interviewees to provide selective accounts and produce structured narratives of their experiences, with a variety of factors influencing what information is chosen to be shared. In studies that have relied solely upon the perspectives of one member of a caring dyad, such accounts are inevitably partial.

Within the debate on care, the favouring of the care provider's perspective upholds a model of care that is 'done to' rather than co-constructed by provider and recipient. More recently, there has been a growing concern to recognise the perspectives and meanings attached to care by those in receipt. The present study will argue for the need for attention to a third and as yet neglected dimension of care. The use of video filmed data in the present study highlights the benefits of attention to care as a dynamic. The act of giving care occurs alongside the active receipt of care. These two experiences unfold simultaneously and interact, creating a care dynamic. Video data therefore facilitates a relational perspective upon care and highlights the importance of viewing care as an interaction.

A common characteristic of many studies of gender and informal care has been the employment of a comparative model in which the experiences of like groups of men and



women have been compared in order to highlight salient areas of difference, arguably with far less consideration being given to similarities. Why such similarities may not also usefully inform an understanding of gender and care remains a moot point. While there appears to be a consensus that differences exist in the meanings men and women attach to providing network care the absence of research that has directly investigated care as it is enacted so far precludes a clear understanding of how this meaning may be jointly constructed. For the present study, the framing of care according to an imbalance of power may be understood as an important influence upon the meanings attached to caring relationships and how contributors to episodes of care are unequally placed in the evaluation of such encounters.

A key argument within the present study is for the need to consider how an understanding of gender informs the way in which caring relations are read. Within the debate on care there has been particular attention paid to care as a gender marked activity. At both concrete and symbolic levels caring is imbued with femininity and femininity with care. However, a notable outcome of many comparative studies is that gender has emerged as a fixed and stable category of identity, underpinning the ways in which care is undertaken. In this chapter, it will be argued that gender is usefully understood as a fluid aspect of social experience and as such, care provides a locus wherein identity is negotiated. Making use of video data allows particularly for a consideration of how gender therefore operates at an interactional level, serving to mediate encounters between carer and caree.

#### Video data:

An introductory analysis has revealed that interaction with care workers comprised the majority of daily contact for each participant. The level of verbal communication as part of this contact was found to be low, and interactions mainly found to be task-based. A comparative case study of two men and two women revealed that gender did not appear to influence levels of input by and contact with care staff.



For this chapter the entire data set of video film (over 900 hours) was scanned, again using an event sampling technique, with particular attention paid to the content of interactions between care staff and residents and between residents. The analysis was conducted in order to select representative examples of interactions and to further build an impression of daily interaction across the eight units. Video film allowed for interactions to be examined and re-examined with attention paid to differing aspects of each encounter, including verbal and non-verbal communication<sup>16</sup>.

### Overview of data

Examination of video filmed data revealed a spectrum of interactions between care workers and people with dementia. A useful device for conveying an overall summary of this range of interactions is a bell-shaped curve. At the centre of the curve, representing the bulk of interactions taking place were task-based episodes of care, containing low levels of verbal input from both provider and recipient. These episodes will be considered in more detail for this chapter and it will be argued represent a communication genre within care.

### Outliers:

At either side of the bell curve were episodes of interaction found to occur less frequently ranging between poles of what, at an observable level at least, may be viewed as positive and negative encounters<sup>17</sup>. Examples of interactions occurring at a negative extreme included incidents where carers used physical force in order to overcome residents' resistance to the provision of care tasks with little effort made to persuade them verbally or consideration shown for the will of the resident. While residents spent the greater portion of their day in social isolation occasions were also observed when they were

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<sup>16</sup> In seeking to provide an account of the communicative context of care home settings, this overview of data once again makes inroads into the domain of the CPCEC project. Descriptions of the features of communication in dementia care, within this study, borrow from the terrain of the wider project in order to provide a context for attention to gendered aspects of interaction.



'actively' neglected, in one incident repeated requests to be assisted to use the toilet were ignored for a period of over two hours, despite obvious signs of ill-being. At the positive extreme were encounters of a wholly social nature, initiated with no apparent task-based agenda. Moments of tenderness and warmth, communicated at verbal and non-verbal levels were observed, often leading to clear signs of well-being for the resident concerned. This included kissing and hugging of residents and/or conversation focussing upon a resident's life, family or present experiences in the care home.

These encounters have been labelled outliers given that they were observed to occur infrequently and were therefore unrepresentative of the bulk of interactions taking place between care workers and residents. Of the more representative interactions, attention will now be paid to the different dimensions of the communication observed to take place. Particular attention will be paid to the differing ways in which gender may be understood as relevant to these encounters and how such encounters may inform a wider debate on gender and care.

## **Speaking Care**

To date, there have been limited contributions to a body of empirical evidence upon which to draw when considering the interactive experiences of people with dementia residing in care, neither is there a developed or comprehensive debate focussing upon this aspect of care. For this reason it is useful to locate care-based interactions within a wider literature upon communication, health care and identity.

In contrast to 'ordinary conversation', Drew and Heritage (1992) have argued that 'institutional talk' is characterised by a degree of standardisation. As the process by which individuals manage the tasks and requirements associated with any given institution, such talk is often marked by asymmetry and, as routine encounters are repeated over time, takes on a standardised form. Many service encounters acquire a repeated format, becoming

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<sup>17</sup> It is important to be clear that judgements as to the positive and negative complexion of interactions are an imposed construct of this study and do not necessarily reflect a shared understanding of care according to the



'naturalised' and 'normalised' within particular settings. Thus, interaction is shaped by context but at the same time is 'context renewing', serving to maintain or 'fix' relations.

With regard to such institutionalised encounters, Heritage (1997) has suggested the metaphor of a wind tunnel. Heritage argues that the repeated participation in a particular type of encounter generates knowledge of the possible responses and an understanding of how certain ways of managing an encounter may be less likely to lead to resistance or argument. As such, a 'wind tunnel' of repetition generates an approach to a routine encounter that is designed to evoke the least resistance. With regard to communication between older people and their carers Grainger et al (1990) have argued that such talk "needs to be interpreted in recognition of institutional frameworks which constrain opportunities for talk and dictate models of talk" (page 209, 1990).

Within health care contexts considerable attention has been given to doctor-patient relations, in recognition that effective communication influences outcomes for health. Gender has been considered within this research on a number of levels. For example, Fisher (1991) has argued that communication by and with doctors and nurses may be understood according to their respective location within gendered occupations, with characteristic differences in how they approach interaction with patients and the nature of that interaction. A study of GP-patient interactions by Ainsworth-Vaughn (1998) found that women ask more questions of GP's than men, while both men and women ask more questions of female GP's. The study also paid attention to the input of patients arguing that an unprompted introduction of sexual topics by patients, represented a power claiming strategy.

Following the identification of an 'ideal sequence' of interaction between doctors and patients, ten Have (1989) has argued that the consultation encounter may be considered a speech genre. Ten Have identified six stages of a consultation, but argued that such a sequence was 'ideal' because a number of deviations, acceptable to both parties, were observable within the data for the study.

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perspective of either care workers or residents themselves.



One aspect of the interactions between care workers and clients with dementia that differentiates them from the examples above, is the possibility that residents may neither fully understand nor welcome the provision of care. The presence of an underlying and/or unspoken consensus between carer and caree may not be assumed by dementia care workers and the absence of a shared orientation to the frame of interactions requires negotiation during episodes of care.

For the present study a baseline of communication was identified from video-taped interactions between care workers and residents. According to the input of carers, the 'care-speak' genre has four distinct stages. This genre of communication was present within all the homes visited during fieldwork and was employed by both male and female care workers, of varying ages and different ethnicities. Care-speak was the main style of communication employed by carers and as such represents the mode of interaction at the centre of the bell-curve described earlier.

The stages of care-speak interactions:

- 1) Opening - an opening was observed to alert a resident to the presence of a care worker and the impending commencement of a care task. It characteristically took the form of a brief greeting or use of the resident's name. Alternatively, at a non-verbal level an opening was often achieved through the use of touch, usually to the arm or hand of the resident.
- 2) Signal of intent - carers communicated the nature of the care task they were about to undertake with the resident. At a verbal level this more usually took the form of a bald statement such as "it's time for the toilet" or "you're coming with me now". Far less often was it framed as a question to the resident, such as "would you like to go to the toilet/come with me now?" The signal of intent was also observed to take place at a non-verbal level, for example, gesturing toward a wheelchair prior to a transfer or holding out a plate of food before assisting a resident to eat.



- 3) Accomplishment of task - despite the variety of care tasks undertaken within residential care, they were commonly achieved through the use of a series of directives, sometimes framed by a narration of the task and punctuated by words of encouragement. Again, this stage of the episode of care was frequently observed to unfold at a largely or exclusively non-verbal level, through the use of guiding touches, gesturing and physical handling of the resident.
- 4) Closing - upon completion of a care task the episode was closed, almost always by the care worker. A closing would sometimes take the form of a brief 'thank-you' or other verbal marker such as 'that's it' or 'all done'. At a non-verbal level a closing often involved the straightening of a resident's clothes, such as pulling a skirt down over the knees. However, the most frequent closing observed was the physical departure of the carer without any spoken ending.

Despite naming this genre of communication 'care-speak', an entire sequence was often observed to take place at a largely or exclusively non-verbal level. Indeed, within the data, wholly silent episodes of care were recorded during which neither care worker nor resident made any verbal contribution whatsoever. The introductory analysis highlighting overall low levels of verbal content within episodes of care attests to the prevalence of such silent encounters. During episodes of care in which a resident complied with a task and/or showed a knowledge of a routine without requiring prompting or direction a common outcome was that carers' verbal input was kept to a minimum. The single most frequent predictor of greater levels of spoken input by carers were circumstances where residents failed to comply with the task or showed uncertainty as to what was expected of them.

Another striking feature of many episodes of care, differentiating them from doctor-patient encounters or other formulaic service transactions was that verbal input from residents was rarely required and often not elicited. The format of directives and narration of tasks and/or non-verbal guiding touch and physical handling served to constrain input



from residents during the completion of tasks. Therefore, within the limited time that carers and residents were engaged in direct contact there was little occasion for the resident to have any spoken input. Indeed, the format of these encounters may be understood to actively preclude input by residents. At an observed level, residents' silent compliance appeared to be the preferred contribution according to the rules of this sequence. Deviation from a focus upon the task at hand may be understood as dispreferred, with a number of strategies employed by carers to maintain focus and to overcome any stalling in the completion of the task.

A number of wider implications arise from these findings. Firstly, it may be argued that an instrumental model of care is achieved and maintained by this sequencing of episodes of care. This model was observed to underpin interactions involving both male and female carers suggesting that gendered differences in the provision of care may be subsumed by the organisational culture within residential care. The care-speak genre may also be understood as expressive of the imbalance of power that frames interactions between care workers and residents with little evidence that residents exercised agency or control during the encounters. Of particular note with regard to this most common form of interaction between residents and carers is that silence rather than speech is the dominant factor in care interactions.

Through care-speak it seemed that residents were positioned as the object of care with little observed or explicit attention to alternative aspects of their identity. At the same time, the utilisation of a standard form of speech served to constrain individual variation on the part of care workers. However, care episodes were observed that deviated from this standard form, in particular on those occasions when residents, for a variety of reasons, failed to comply with the task at hand. Under these circumstances greater variation was observed according to how both care workers and residents employed strategies to manage the situation.

Responses to non-compliance and resistance:



In studies of interaction between older people and formal carers attention has been given to the strategies employed by carers to both manage care tasks and achieve their completion. Through analysis of interactions between care workers and older people residing in care, Coupland et al (1988) have argued that the use of politeness needs to be understood according to the context in which it is employed. Polite requests and the use of 'in-group' identifiers by a nurse, when coercing a care home resident to take medicine were argued to be a redress of the nurse's 'face' while undertaking an act that potentially threatens her identity as a caring individual and competent professional. The authors argue that it is the act of coercion rather than the verbal request to the resident that represents the face threatening act (FTA) within such an interaction.

A study of the use of controlling language, by nurses caring for older people (Lanceley 1985), identified a range of verbal strategies employed by staff to assert 'interpersonal dominance' during interactions with patients. Such devices included the use of 'pluralisation' in which nurses used 'we' rather than 'you' in order to encourage a patient's alignment with the nurse's perspective. Softeners, such as 'just' ('I *just* want you to lie on your side), were viewed as softening direct commands, while tag questions were employed to negotiate patients' resistance by appearing to offer them a choice. In a study of 'painful self-disclosures' (PSD) made by older people to their carers during care provision, Grainger et al (1990) found that the most common response by carers was a strategy of deflection and/or redefinition. Such strategies served to maintain a focus upon the care task at hand. The authors concluded; "deflection can in this way be seen as a means of protecting the integrity and efficiency of caring routines" (page 205, 1990).

Video data made use of for the present study revealed numerous occasions when residents resisted or failed to comply with care tasks. One limit of such data is that the reasons and motivating factors underpinning non-compliance can only be speculated upon. Similarly, there is no certainty as to what factors may underpin the choice of response by carers. Various options for responding to non-compliance were observed being employed within the data. These included the choice of:



- Desisting - desisting from or postponing a care task serves to recognise the will and preference of the resident. It may be understood as an affiliative strategy that moderates the experience or exercise of control.
- Verbal persuasion - such persuasion included the use of politeness, bargaining, in-group identifiers (such as 'darling', 'sweetheart' or use of the resident's first name) and encouragement.
- Coalition - responding to resistance included intervention by a second and sometimes third carer who would join the interaction to further persuade a resident to comply.
- Enforcement - at a verbal level this took the form of authoritative commands by a care worker, at a non-verbal level it involved the use of physical force and restraint.

Of particular interest to the present study was how gender was observed as relevant to such interactions and the manner in which it mediated the unfolding encounters.

### Referencing gender

One form in which gender was observed as present in the interactions of care providers and recipients was occasions when gendered identifiers were employed during episodes of care. In the following example a male carer approaches a female resident who is sat in a wheelchair at the dining table. Plates are being cleared and residents are being assisted to move back to the communal day room. The duration of this episode is 2 minutes and 36 seconds, c. = carer, r. = resident, (underlined words = emphasis of intonation)



## Example 1

### Verbal

1. c. -Let me see if I can help her
2. c. - Vera, this is your fish, you didn't take any, can I help you? (pause in speech of 23 seconds)
- 3.- c. - chips
- 4.- r. - don't want any
5. c. - chips
- 6.- r. - don't put that on, you, you
7. c. - okay I'm waiting
8. r. - the other one
9. c. - oh the other one, okay then
10. r. - yeh
- 11.- c. - fish, good girl
12. c. - what are you doing?
13. r. - what?, go on
14. c. - okay, okay then leave it, leave it, it's alright
15. c. - Vera, you're a good girl you know, you're a good girl
16. r. - yeh?
17. c. - yes, so leave that, leave it now, good girl
18. c. - okay
19. r. - I don't want it
20. c. - you don't want this?/r. - no
21. c. - what do you want then? Do you want the peas, do you want this?
- 22.c. - it's good taste it/r. - no, nothing
23. c. - are you sure? Okay take a little of the chips
24. r. - no, NO
25. c. - take it easy, why are you shouting, okay, what are you shouting for?

### Non-verbal

1. carer approaches resident at table
2. carer stands over resident at her left side, he leans on the table, while chopping up food on the plate
- 3.- offers a forkful of food
4. resident shakes her head without looking at carer
5. carer offers fork to lips a second time
- 6.- resident shrugs food away and looks directly at carer, holding her gaze
- 7.- carer holds out food
- 8.- resident gestures at plate
- 9.- returns fork to plate and gathers more food
- 10.- carer offers fork to resident's lips
- 11.- resident opens mouth and takes food
- 12.- resident reaches out and picks up knife from table
- 13.- carer takes knife from resident
- 14.- carer places knife on table
- 15.- resident picks knife back up from table
- 16.- resident looks at carer
- 17.- carer takes knife a second time
18. carer offers another forkful of food
- 19.- resident pushes carers hand away with her hand
- 20.- resident shakes her head
- 21.- carer holds out another forkful of food
- 22.- resident shakes her head
- 23.- carer offers up fork to lips again
24. resident screams out last 'no' holding the 'o' for five seconds
25. carer pats resident's shoulder with his hand, pauses then gets up and leaves.

Studies within institutionalised care environments for older people have paid particular attention to the phenomenon of 'baby-talk' or infantilisation. Studies by Caporael et al



(1981, 1983) found that secondary baby talk was a distinct speech style used with institutionalised older people. While these earlier studies suggested that such a style may be perceived as communicating nurturing support, Ryan and Cole (1990) have subsequently argued:

"Stereotyped-based speech strategies cannot be universally successful because of the great diversity in communication needs and preferences among older people sharing the social category of elderly." (Page 174, 1990)

As has been highlighted by Grainger et al (1990) baby talk has mainly been considered in relation to surface syntactic and prosodic features, with less attention given to discourse level characteristics. Of particular note for the present study is that a great deal of the baby talk observed within the data was gendered. Indeed, baby talk was the most common occasion when gendered identities were ascribed to residents and utilised in communication between care workers and residents. As the episode above demonstrates, baby talk serves a number of purposes in relation to care task completion.

In line 7; 'okay, I'm waiting', the carer indicates to the resident that the task at hand is oriented to the carer's time frame. The first use of 'good girl' in line 11 is used to reward the taking of food. The use of 'good girl' serves to encourage the resident, while invoking a power imbalance through signalling a parent/child dynamic. The use of baby talk may also be understood as employed to overcome the initial signs of resistance by the resident at line 6. As the resident presents further resistance to the task; taking hold of the knife and resisting attempts by the carer to take the knife away, 'good girl' is used again. Such baby talk is suggestive of social proximity between the carer and caree while asserting a parental form of authority within the episode of care.

In the example above, the use of 'good girl' represents an example of a wider process of categorisation. It works within this interaction to both reward the resident and maintain orientation to the task at points when this is stalled by her conduct, framing such behaviour as dispreferred, in a manner that contests an assertion of will by the resident. Thus deviation from the care task generates 'parental' disapproval. Infantilisation



disempowers the resident, negating her attempts to exercise agency during the encounter while positioning the carer as a parental figure whose approval is associated with task completion.

Referencing gender in the process of categorisation was observed to fulfil a number of functions. Gendered labels were most commonly invoked during task completion, operating in both a regulatory and rewarding capacity. They were also called into service when constructing a reputation for residents within care homes. Example two, is taken from fieldwork diaries.

(30/1 - 2.40pm) A (female) volunteer is querying why a particular resident who has repeatedly asked to be moved is being left where she is. The volunteer approaches a carer who states: 'she's a right madam, that one'.

This gendered label, an indirect response to a (female) resident's request for support suggests that her request extends, in some way, beyond her status. It serves the function of explaining why support has not been offered (in this instance to a volunteer) but also communicates disapproval to the resident. The volunteer's query may be understood as potentially critical of the care workers' practice, and as such is face threatening for the carers involved. The labelling of the resident as 'a right madam' is therefore face-saving while serving to 'enculture' the volunteer, encouraging her to re-align with the care worker's perspective<sup>18</sup>. Such public categorisation may also be understood to contribute to the reputational standing of the resident, within the care home environment. Again, it contests an assertion of will by the resident while justifying the care workers' lack of input or assistance. The request is therefore framed as unreasonable according to the wider (gendered) reputation of the resident in question.

### The care dynamic (part one) - Complimenting

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<sup>18</sup> The label is also interesting for being an idiom of speech for which there is no equivalent masculine version.



Within the existing literature on institutional care for older people a key theme identified across a number of studies is the existence of conflicting agendas, on the part of providers and recipients. This conflict may be characterised as a disparity between a task-oriented approach by staff and a desire for social engagement expressed by residents (Bender and Cheston 1997, Edberg et al 1995, Grainger 1990, Iwasiw and Olson 1995, Small et al 1998). To date limited attention has been given to how such a disparity is negotiated during care provision.

Of pertinence to this debate and relevant to the present study is the payment of compliments during episodes of care. Compliments provide a useful insight into this process of negotiation, their payment and receipt serving to demonstrate the conflicting interests and concerns of care providers and recipients. Attention to this particular formulaic speech act is supported by the finding that compliments were used regularly during interactions between those living and working in care, they are therefore a repeated and common feature of interaction in these settings.

A compliment may be defined as:

"A speech act which explicitly or implicitly attributes credit to someone other than the speaker, usually the person addressed' ... 'which is positively valued by the speaker and the hearer." (Holmes, page 446, 1988)

A study by Wolfson and Manes (1980) suggested that compliments serve an 'underlying social function of creating or reinforcing solidarity' (page 391, 1980). With regard to the receipt of compliments, Holmes (1993) noted four main strategies: acceptance, rejection, deflection or evasion. However, existing studies have highlighted the absence of attention to the social and discursive context in which compliments are employed and the consequent difficulties of understanding their functions in particular settings and situations (Holmes 1988, Johnson and Roen 1992).

Gender and complimenting:



Existing research on compliments has highlighted gendered differences in the use and types of compliments suggesting that they are a gender-marked aspect of speech. A particular feature of existing studies is that complimenting appears to be organised by gender. Men have been found to pay fewer compliments (Knapp et al 1984, Holmes 1988, Herbert 1990, Johnson and Roen 1992) and the types of compliments they pay tend to focus upon possessions (Holmes 1988)

In contrast, women have been found to both give and receive more compliments (Sims 1989, Holmes 1988, Johnson and Roen 1992). With appearance-related compliments being the most common form used (Knapp et al 1984, Holmes 1988). Holmes (1988) found that such compliments often 'wrapped' social interactions, forming part of a wider greeting or farewell sequence.

A number of studies have argued that such differences are indicative of wider gender differences in communication and that compliments serve differing functions for men and women (Herbert 1990). Johnson and Roen (1992) suggest that compliments by women most commonly function as offers of solidarity while the less frequently used compliments by men are better understood as actual assertions of praise. Holmes (1993) has argued that the use of compliments and politeness by women are part of 'clearly definable female norms which put the addressee's interests and needs first' (page 112/3, 1993).

Video analysis for the present study revealed that compliments were a regularly employed speech act for at least four of the female participants within the study. The introductory case study analysis found that one female resident paid twelve compliments over a three-day period, despite an observed difficulty in maintaining prolonged exchanges. Based upon existing research, it is possible to speculate that the predominance of women within care home environments would lead to such settings being 'compliment-rich', with frequent use of appearance-related compliments. Holmes' proposal that women employ compliments as positive speech acts in order to facilitate social rapport, may inform an understanding of their use within care facilities.



As previously noted, the 'care-speak' genre employed by carers served to maintain a focus to the task at hand and facilitate completion expediently while limiting deviation. It may therefore be argued that this agenda provides a frame for understanding the use of compliments by care workers. The compliment sequence in example one above provides a representative instance.

- 15. c. - Vera, you're a good girl you know, you're a good girl
- 16. r. - yeh?
- 17. c. - yes, so leave that, leave it now, good girl

The (male) care worker pays a compliment to the (female) resident that may be understood as seeking to establish rapport, paying attention to the resident's 'positive face' through the act of attributing credit to her personality. The use of baby talk within the compliment offers an insight into the importance of understanding such speech acts within context. The phrase 'good girl' activates a power imbalance within the care episode in a manner that disempowers the resident through the act of complimenting her. Within the wider sequence of the episode of care it was also noted that the compliment is paid as a response to the first indication of resistance by the resident and may therefore also be understood to have a strategic function.

When considered in relation to the wider communicative context of the care home environment it may be argued that compliments function as a particular social strategy during care provision. The response received by these compliments may also serve to enhance an understanding of the interactions between carers and residents. The following representative examples are taken from interactions between different caring dyads of (female) residents and (female) care workers.

Compliment 1: A carer approaches a drowsy resident with the (spoken) intention of assisting her to use the toilet. The resident is sat with two others in the corner of a communal day room. The entire episode lasted for one minute and fifty seconds and began



with the care worker assisting the resident to transfer to a wheelchair. r = (female) resident, r2 - (female) resident sat opposite, c. = (female) care worker

Verbal

Non-verbal

<div>1. r. - thank you/ c. - alright, put your leg down here.</div> <div>2. c. - ooh</div> <div>3. r. - yeh, and you're lovely/ c. - you too</div> <div>4. r. - lovely hair, oh I'm cheeky</div> <div>5. r2. - mind your back/c. - let me get this one.</div>	<div>1.- Resident sits in wheelchair and looks up at carer who bends over and pulls left footrest round and guides resident's leg with her hand.</div> <div>2.- Carer holds arm rests of chair and swings chair to her right, she pulls out the right foot rest and then straightens up and stands facing the resident.</div> <div>3.- Resident looks at face of carer while paying compliment, carer points at resident while she repays the compliment.</div> <div>4.- Carer bends over in front of resident as she straightens the chair, her hair hangs down in front of the resident who reaches out and touches it, while she pays the second compliment. The carer laughs as she walks behind the wheelchair and manoeuvres it round.</div> <div>5.- Carer squeezes past second resident and leans forward to take the brake off the wheelchair.</div>
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Compliment 2: A female carer (c.) approaches a female resident (r.) as she is sat in the communal day room, asking what she would like to supper. The resident replies that she would like fish. The entire episode lasted for one minute and sixteen seconds.

Verbal

Non-verbal

<div>1.- r. - When is it? When is it young lady?/c. - what?</div> <div>2.- r. - When the fish comes to the (pause) top? Soon, soon? No? Yes? (laughs)</div> <div>3.- r. - can I tell you something, you've got</div>	<div>1.- Resident sits forward in chair and tilts head, looking at carer. Carer looks up from her clipboard.</div> <div>2.- Resident places her hand on the carer's arm and maintains touch.</div> <div>3.- Resident places her hand on the carer's</div>
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<p>a beautiful smile/c. - really?</p> <p>4.- r. - yes beautiful, I'm not giving you any brag, it's true (pauses then laughs).</p>	<p>hand, the carer continues to leaf through papers on her clipboard</p> <p>4.- Resident sits back in chair, she raises her hand palm upwards. Carer continues to look at clipboard and does not respond to the compliment. The carer then turns to another resident asking what she wants for supper.</p>
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Compliment 3: This episode involves a female resident (r.), who is sat in the communal day room. She is approached by a female care worker (c1.) who is holding a cup of tea. A second female care worker, is standing in front of them (off camera). The entire episode lasted for two minutes and seventeen seconds and continued with the carer assisting the resident to drink her tea while speaking with the second carer.

Verbal	Non-verbal
<p>1.- c1. - hello Lottie, hello Lottie, how are you dear?</p> <p>2.- r. - yeh, mmm, you're lovely you are, yeh</p> <p>3.- c1. - come on, have some tea now, drink some tea?/r. - yeh, yeh.</p>	<p>1.- Carer approaches resident and sits down in the chair to the resident's left. She twists round to face the resident. The resident sits forward as she does this.</p> <p>2.- Resident takes the carer's hand in both her hands and kisses it, then looks up at the face of the carer.</p> <p>3.- Carer lifts cup up towards resident's face. Resident puts hand to side of cup and takes a sip, she starts to cough and the carer puts her hand on the resident's back and slowly pats her.</p>

Compliments in context:

Video analysis revealed that a common outcome of the use of 'care-speak' was that the spoken content of interactions was constrained to task accomplishment. Neither residents nor carers were observed to offer much in the way of personal information about themselves during these interactions. When undertaking care tasks, carers are required to enter the personal space of residents, they touch and handle residents during task



completion and may also use touch to enhance spoken communication. Rarely do occasions arise when residents may legitimately touch carers. Therefore, throughout much of the communication between carers and residents there is a largely one-way flow of both verbal and non-verbal input from carers with few opportunities for this to be reciprocated.

Within this wider communicative context, residents' use of compliments serve a number of observable functions. The paying of a compliment may be understood as an attempt to establish or shift the footing of interactions to a more social focus, given their deviation from task accomplishment. The use of compliments also serve as a means by which a resident may make an acceptable verbal contribution to episodes of care in a context where the series of commands issued by carers and their narration of tasks often inhibit this.

In all three examples above there are some clear non-verbal correlates to the payment of compliments by residents. On each occasion when a compliment is paid the resident is observed to initiate touch with the carer. This breaks the one-way flow of physical contact and may, again, be understood as a vehicle for changing the footing of task-oriented episodes of care. The compliment therefore appears to offer an 'acceptable' occasion for a resident to use touch. Combined, the spoken compliment and its non-verbal accompaniment enhance the dialogic quality of interactions.

Carers' responses to the compliments were also revealing. In all three examples the carers continue with their focus upon the task at hand. The compliments do not serve to alter either the overall verbal input or physical activity of the carer. When comparing these examples to existing studies, some interesting comparisons emerge.

The use of compliments by residents, with particular attention paid to the addressee's appearance, are in line with findings regarding the use of compliments by women to establish or maintain rapport and solidarity between speaker and addressee. However, the overall function of the compliments within these episodes of care is less representative of previous findings. The compliments were not observed to achieve or maintain a socially-



oriented footing to interactions thereby highlighting a differential in the perspectives (and agendas) of carers and residents. This finding may support Holmes' (1986) argument that rejection or evasion of compliments indicates their perception as face-threatening, assuming greater intimacy than the recipient feels comfortable with.

Overall, carers' handling of compliment sequences and the maintenance of a focus upon care tasks is therefore in keeping with existing research on care home interactions, but deviates from wider findings regarding gender and politeness. This highlights the importance of attention to context in the study of interaction and the limits to generalised models of gendered interaction.

#### Speaking care: Conclusions:

A model of 'care-speak' as a genre of communication has been presented and it has been argued that this dominant genre provides a communicative context within which to examine caring relations. The manner in which a particular setting both shapes interaction and is upheld by it has thereby been explored. Video data has also allowed for an analysis of verbal communication alongside accompanying non-verbal interactions, this correlation between speech and action is rarely explored within existing studies of care settings.

It has been suggested that residents make an active contribution to episodes of care, despite the strategies employed to limit this. Attention to complimenting in care suggests that such contributions are often mediated by gender, as residents seek to assert their own, differing, agenda upon their encounters with care workers.



## Feeling Care

The use of video taped data for the present study offers a number of benefits in the investigation of gender relations in a care setting. Attention to routines, communication and social relations has highlighted the differing levels at which gender is manifest and relevant. In their study of institutional talk, Drew and Heritage (1992) have argued:

"The direct focus on recorded conduct has the advantage that it cuts across basic problems associated with the gap between beliefs and action and between what people say and what they do." (page 50, 1992)

However, limits exist to this type of data and the analysis that stems from it. Video data does not provide access to a clear understanding of the intentions or motivation that lie behind the action as it unfolds. The meaning that is attached to events, at an individual level can only be speculated upon, with any subsequent judgements therefore an imposition of the study rather than a reflection of the perspectives of those involved.

Within the debate on care, gendered models of care have been premised upon the proposal that women are more likely both to attend to the emotional aspects of a caring relationship and to report an emotional impact from undertaking care. For this reason, attending to the manner in which caring is made sense of and the meaning that it holds for those who provide care is a crucial consideration for the present study. Attention to subjective accounts of care also allows for a consideration of the differing dimensions of emotion within care.

Within existing accounts of emotion, Edwards (2001) has argued that little concern has been shown to differentiate emotion states from 'emotion discourse'. Rules apply as to how emotions are accounted for, thus feeling rules determine what emotions are appropriate in particular situations and as such may structure the accounts given of emotion states. Historically, Showalter (1987) has highlighted the gendered construction of particular emotions or feeling states, such as hysteria. Findings that have identified an association



between emotion discourse and women's accounts of care may also be an indication that, at a wider level, emotion discourse is gender marked, more readily accessible and perhaps more acceptable as a feature of feminine narratives.

#### Dimensions of emotion at work:

The notion of 'emotional labour' coined by Hochschild (1983) to describe the 'commercialisation of feeling' in the airline industry and in debt collection, has increasingly been understood as a distinguishing feature of much interactive service sector employment. Hochschild describes emotional labour as 'the management of feeling to create a publicly observable facial and bodily display', which carries an exchange value in particular areas of employment. Such labour often receives little recompense for workers and the impact of this aspect of work upon the individual receives little recognition within organisations. It is argued that emotional labour is often associated with areas of employment predominantly populated by women, given their concentration in interactive service sector work.

Another component of Hochschild's study was a consideration of the impact of emotional labour. The study highlighted the sense of disparity (alienation) felt by many workers, between the social front they presented at work and the emotions this disguised. An important and aggravating factor was the lack of opportunity for flight attendants to express their feelings.

In a study of network carers of people with dementia, MacRae (1998) has highlighted the degree of emotion work required during care provision. MacRae argues that strain emerges from the tension between 'feeling and feigning' as carers manage their emotions, often concealing feelings of sadness or anger.

With regard to formal care, Twigg (2000) has argued that the notion of emotional labour is valuable to the conception of care as paid work. Twigg suggests that it serves to disentangle the feeling aspect of this type of work from the "norms and values that attach



to kinship and family obligation" (page 161, 2000). In a study of the relationships between care assistants and older people in residential care, Lee-Treweek (1996) has identified a further, less positive, dimension to emotion work. Lee-Treweek argues that there is a popular association of care with notions of nurturance, comfort and protection, while control and coercion have remained 'the hidden side of care'. Lee-Treweek differentiates 'emotion work' from 'emotional labour' on the grounds that it represents a chosen aspect of carers' work. Emotion work functions to empower care workers, creating order in their working environments while serving as a coping strategy in relation to the work undertaken.

Two key aspects of emotion work identified by Lee-Treweek were, firstly the interventions by care workers to manage the emotions of residents, with disapproval shown toward the expression of heightened emotion. Secondly, the manner in which care workers employed emotions manipulatively in order to control residents. This controlling use of emotion is tied to the reputational standing of residents who are categorised by care workers in a manner that either earns attention to their feelings or a denial of them.

Twigg (2000) identified a tension between a personalised ethic of care, held by carers, and the structuring of their work according to the imperative to complete set tasks within pre-defined time limits. The study highlighted that such tensions and the strain that is generated by them are rarely accounted for, or attended to, in representations or conceptualisations of formal care. It is argued that the emotional tensions that are integral to paid care serve as indicators of the essentially unbounded character of care that rarely informs discussions of paid caring.

The overall lack of attention given to the perspectives of paid care workers within the debate on care places limits upon the construction of a comprehensive model of formal care, not least in relation to emotional content.

"The whole issue of emotion is dealt with in a rather confusing and one-sided way in much of the caring literature. It is confusing principally because no clear distinction is made between 1) the privately experienced emotional or feeling state



of the person doing care work and 2) the publicly expressed 'emotional input' of the carer in the caring relationship." (Thomas, 1993, page 663)

This brief review of existing research draws attention to the various dimensions to emotion work and labour in relation to care provision. The manner in which organisations impose 'feeling rules' upon workers and the strain that is generated from adhering to these rules represent but one face of emotion at work. Alongside this, the use of emotions as a means of control and regulation has been shown to be a feature of care provision and one that is largely overlooked. It may therefore be argued that a more comprehensive typology of emotion at work is required. Interviews with care workers for the present study identified a number of ways in which emotion was relevant to formal care of people with dementia. In line with findings that emotion is often attended to in accounts of care by women, many respondents offered indications of how it feels to provide care.

#### Emotional labour:

Hochschild's (1983) notion of emotional labour proved relevant to carers' accounts of their work. During interview, respondents highlighted the need to be aware of how they present themselves emotionally:

"With the type of job you're doing you don't need to bring your stress here, because you are working in the EMI Unit and it's a dementia floor, they don't need you to come up and bring your stress to them." (rhec19(f))

"When we come out of the office happy I don't know how to say it but the resident can sense, pick up on you' ... 'Especially this unit, (we) need to be the happy staff (because) the people will really sense it." (rhec9(f))

"(One resident) is always nasty to us because she is nasty towards everybody but at the same time I still have to give her the care that she needs. It's difficult but you just have to divide your emotions, you can't think about things, just think about the care really and just move on." (rhec18(f))

Implicit in these responses is the sense that in order to provide care effectively there is a need to present a stable and positive affect, which echoes the ever-smiling persona



adopted by flight attendants. However, an ethic of care is discernible here also, according to which there is a need to withhold the expression of negative emotions when working with a client group who are perceived as sensitive to emotion states and perhaps vulnerable to them. Such responses may be read as rationalising the feeling rules that are organisationally enforced. However, in their attention to the well-being of residents these responses serve to blur the boundaries between the use of emotion to meet wider organisational interests and as upholding a more personalised 'contract' that underpins care work, shaped by a responsibility to residents.

#### Emotional impact/cost:

During interview, carers also offered accounts of the various aspects of their work that were viewed as having an impact upon them, emotionally. Contact and interaction with residents was one such source. Respondents highlighted the impact of working with individuals who were, at times, distressed or in a state of ill-being.

"She was sitting there crying and it was really hard to sort of see someone in such distress and not be able to help them, I mean I was just sort of hugging her but I couldn't find out what caused it and I never did." (rhlc15(f))

"Sometimes it makes me feel helpless and angry as well, especially when you can see the person, especially when you can't tell if the person is in pain and you can't know exactly what is wrong with the person, it becomes difficult to help." (rhec1(m))

The feelings generated through working closely with people in distress were described as heightened by the difficulties in communicating. As the main source of contact for residents, carers also bore an emotional burden when targeted by angry or frustrated residents. However, carers also offered accounts of tensions between staff as carrying an emotional burden.

Another source of emotional burden, signalled by interviewees, was the tension created by working conditions and the disparity between the job they wished to do and that which



was required of them. This tension led to the portrayal, in interviews, of two models of care; 'actual care', as perceived by the workers and 'ideal care' which was presented as difficult to achieve due to a number of obstacles often related to the conditions under which they worked.

"Because of the shortage of staff we can't provide what we want to provide, you know, we don't have enough time to sit with them and spend quality time with them." (rhec9(f))

"I'd like to help them more, I feel like I can do much more than taking care to help them to, for them to live like a normal person. If I can give them good care they ask me for, I could give good care just to listen to what they want, then help them." (rhkc12(f))

"There's so much going on and you have to give so much to everybody in an ideal world you'd have plenty of time for everybody but it doesn't work that way." (rhlc15(f))

The actual/ideal dichotomy constructed by carers in the accounts of their work highlights a tension that is productive of stress and burden. It is also interesting in that it sets an instrumental and task-based approach to care against a more social and relationship-oriented model that is presented as outside of, or marginalised by, the culture of care within the workplace. Such examples offer an insight into the personalised contract that carers develop in their work and the challenges they perceive to fulfilling this. Citing working conditions as obstacles to ideal care may also be understood to maintain the integrity of care workers as they construct a public identity during interview. Thus, a coherent and consistent approach to caring and a self-image as competent and committed is maintained through an ascription of the more negative aspects of their practice to conditions that are imposed upon them and over which they have little control.

Linked to the emotional impact of working closely with people, who at times were in distress, was the requirement of care workers to interpret the emotions of residents. Interviewees offered accounts of occasions when they sought to ascribe feeling states to residents and the emotions generated from the uncertainty in doing this.



"One of them I could tell what she wanted by her eyes, the way her eyes were but I don't always know how I did it but you tell by the expression in her voice."  
(rhfc23(f))

Reading the mood and feelings of residents represents a form of emotion work by carers and offers a clear example of the payment of attention to the 'feeling worlds' of residents. For residents with a deteriorated capacity to communicate verbally such emotion reading may be understood as key to the provision of care and the maintenance of a relationship with that individual.

Emotional management:

Respondents offered examples in which emotions were generated through the work they undertook and the difficulties associated with containing or setting limits to them, echoing Twigg's (2000) argument that care has an unbounded quality.

"I can't cut off I must admit I can't leave, I mean I couldn't be there and go home and think 'oh well forget that client now I'm at home and I can't do that here, just go home, I still worry I'm just a person who cares about my clients.'" (rhfc23(f))

"I can't have a conversation at home without bringing the residents into it, I can't. One of my friends said when are you going to divide your work from home? I can't." (rhec18(f))

Emotional investment:

Relationships with residents were reported to be a source of fulfilment, giving carers a sense of pride in their work. However, an emotional investment in relationships with residents was described as carrying a cost to workers.

"(Name of resident), she was a darling to me but she suffered from mild dementia as well and she used to scream quite a lot which was disturbing the other residents and then they removed her from the home, I cried for weeks, that was very distressing for me. When they die, you know they have to die, it's hurting me, it's



hurtful. You know you cry for a while and then you move on, but I still think about her." (rhec18(f))

#### Emotional support:

Tied to emotional investment at work is the question of what support is given to workers at a wider organisational level. Hochschild's account of emotional labour has highlighted the paradox wherein workers' emotions are utilised for organisational ends largely without recognition or recompense. Another dimension to this, highlighted by the present study, was the manner in which emotional investment (as distinct from labour) garnered limited on-going support.

With regard to support in the workplace, of the 26 carers who spoke about this (n.6 = information missing), 14 (54%) stated that they felt well supported at work. Four carers made specific mention of the telephone counselling service that was available to carers 'it's like the Samaritans, I suppose', but all stated that they had not made use of it. Three interviewees mentioned supervision as a source of support.

Of those offering a more mixed view of support at work, five (19%) carers indicated that support was available on occasion, the presence of support and ability of accessing it being dependent upon workload. These responses suggest that periods for reflection upon work and for 'time-out' to speak about the stressful aspects of their work was not structured into carers' working day, in a formal manner.

A further seven (27%) care staff indicated that support at work was poor. One worker stated that she felt there was no support available at all, whilst others highlighted the specific issues arising from work with people with dementia and the need for a greater appreciation of this at a wider organisational level. Overall, these responses conveyed a sense that attention to support was secondary to the priority of a task-based workload.

"I think maybe people should be required to talk more freely, to talk about how they're feeling, whether it's negative or positive. I think people are afraid



sometimes to talk about the negative or say how stressed out they are because sometimes, maybe it's not acceptable." (rhbc20(f))

#### Emotion and control:

Lee-Treweek (1997) has argued that paid carers be viewed firstly as workers and secondly as carers so that 'the potential for resistance can be revealed' (page 49, 1997). This perspective highlights the connection of gender and class within paid care work. Drawing attention to the use of emotion as a means of regulation by carers, Lee-Treweek argues that 'clean, orderly and quiet residents' represent an end product of care work, achieved in part through such emotional control. As previously noted, a large majority of carers (72%) indicated they enjoyed better relationships with some residents than others. Interviews provided an insight into the processes of categorisation of the client-group and thereby of the manner in which attachments were established with some whilst withheld from others.

"There are attention seekers and those ones when they can't get what they want they get aggressive and angry and then those who are happy in the environment, talk to anybody and do what they are asked to do." (rhcc22(f))

"Yes, we like some more, all the permanent staff here, I do like so and so and another likes so and so, you know the carer has special. If I like somebody I want to do something, like (name of carer) likes so and so, she gives chocolate to them, and looks after (in) a special way, you know, a little cuddle, if (name of carer) like somebody she do special.' ... 'I find quite a few of us (are) like that". (rhec9(f))

These responses highlight the manner in which emotion is invested unequally across the population of residents and, as Lee-Treweek has noted, this is tied to the reputation that differing residents acquire within care settings. To be a 'special' resident in the eyes of a carer clearly carries important emotional value in a context where carers represent the main source of social contact for residents. The label of 'attention-seeker' serves to explain and, according to carers' accounts, to justify the limits they place upon the input for some residents.

#### Control of residents' emotions:



Another facet of carers' accounts of emotion work was the perceived requirement upon them to monitor and regulate residents' emotions. In addition to seeking to alleviate negative emotions and distress, carers reported intervening in disputes between residents in order to limit angry outbursts and uphold rules of conduct.

"We have to see that they are communicating together you know, properly, not abusing each other you know, if they are abusing each other we try to stop it, so if you are there nothing will go on and they will just stop it." (rhkc12(f))

"Well sometimes, if there's two residents sort of like arguing with each other, you have to come between them, try and calm one down and try and calm the other one down.' ... 'But that's if there's someone there, what they would be like if there was no one in the lounge, they could be doing all sorts of things". (rhec14(f))

These responses offer examples of the imposition of feeling rules upon residents and their association with reputation. Expression of emotions, especially of a negative complexion, are kept in check by carers with offending residents categorised as 'awkward' or 'difficult'. Arguments and disputes stand outside of 'allowed' interactions. In these examples, carers present themselves as arbiters in situations where residents cannot be trusted to observe the rules of the care setting without such regulatory input.

### Emotion at work: Conclusions

While by no means exhaustive, the above typology represents an attempt to further disentangle distinct aspects of emotion at work. Hochschild's (1983) original treatise, connecting gender and class and highlighting the exploitative relations of employers to a (largely) female workforce may be understood as relevant and applicable to contemporary paid care. However, through attention to the variety of levels at which emotion is manifest within dementia care it is possible to both extend this critique and demonstrate the limits to it.



Overall, the findings of the present study have demonstrated that it is possible to locate emotion at a number of levels within care work. Emotion exists as a jointly negotiated and interactional feature of encounters between residents and care workers. Positive and negative emotions are expressed as part of the input that both parties make to interactions, while regulated according to the imbalance of power between carers and residents. Emotions are also read and interpreted, by no means always successfully and this process is engaged in both by carers and residents, in the struggle to overcome communicative impairment. At a wider relational level, emotion can be withheld or offered differentially both as a means of control but also as an indicator of the quality of a particular relationship and in the maintenance of that relationship. At an internal level a variety of emotional costs are attached to care work, generated by negotiating tensions within the work, investing in relationships with residents and the disparity between feeling states and the observance of feeling rules.

Support for emotion work, as perceived by carers, has been presented by some as lacking and/or inconsistent. The very lack of support adding to the burden carers experience as part of their work. This highlighted another inconsistency in the workplace experience of care. Whilst carers' were encouraged to foster 'false kin' relations with residents and to view their work as an extension of familial caring relations, there appeared to be few structured opportunities for them to express and share their feelings of loss and grief when residents deteriorated or died. The paucity of support or opportunities for discussing and expressing emotion arguably highlights an organisational view of emotion work as a naturalised feature of the attributes that women are assumed to bring to interactive service work.

The accounts of emotion at work given by care workers for the present study, illustrate that emotions are influenced and managed according to imposed feeling rules but also at a more autonomous and individualised level and by no means in a wholly positive fashion. Variation between the accounts given by individual workers highlights the importance of considering emotion at work as shaped by individual approaches and not least the construction of personalised 'contracts' by workers. The negotiation of what may arise as a



tension between caring for and caring about clients takes place at an individual level and has been shown to vary between the relationships that care workers have with individual residents.

Of particular interest is the degree of apparent dissonance between the uniform and largely task-oriented provision of care observed from video data and the accounts by care workers that suggest a far more complex relationship between the providers and recipients of care. Clearly, evaluations of care premised largely upon observational methods are likely to overlook the many components of care that exist at a personal and felt level. The often non-verbal and internal quality of emotion work may be understood as largely hidden from observation techniques and by association from a wider understanding of care.

It has been argued that the construct of 'ideal care' may be understood as a device for maintaining a positive self-image as a competent carer within public accounts offered by carers. Given the gender-marked character of care and the manner in which care may be understood to contribute to the construction of femininity, it may be argued that such a self-image holds particular importance for women, as carers (and carers, as women). With regard to their work, respondents indicated that a burden is associated with failing to provide 'ideal care'. As a model of care that is presented as outside of and compromised by organisational requirements, the question arises: from where this model of care is learned or imported, if not from network caring experiences? Also, why should the struggle to achieve 'ideal care' be presented as a source of burden if not informed by the gendered obligations and duties associated with care provision within familial networks?



## Doing care

### Bodywork:

Care, as a paid, institutionally organised and regulated activity is a key component of the welfare state. Yet, what is known of care, as labour, is partial and incomplete. Twigg (2000) has argued that neither the practice nor politics of bodywork are adequately attended to in discourses of care, signalling the manner in which it is tied to assumptions that care is an unskilled and naturalised aspect of women's work. A shared understanding of what formal care involves and what it is like to provide care in a paid capacity is organised around a number of dominant concepts and theories that seem to owe little to accounts of care from those undertaking this form of labour.

"The neglect of paid work on others' bodies as a factor in employment is also due to the fact that the distinctiveness of social relations of work in the service sector has been theorized mainly through the notion of emotional labour". (Wolkowitz, 2002, page 499)

In a study of hospice care, James (1992) has argued that a hierarchy exists for care workers as to how work is undertaken and prioritised. James found that hospice settings were oriented to the physical labour associated with care work and for this reason proposed that the patient be understood as a product of labour, their needs and perspectives subsumed by a focus upon tasks and orderliness within a 'dominant biomedical physical system'. Despite the centrality of emotional labour to an understanding of care work, in care practice this labour often proves an 'add-on' to the precedence of physical work. Prioritised concerns within much of the discussion of paid care therefore poorly reflect the structuring of the labour itself.

Such a perspective was supported by findings generated from video-taped data for the present study and from the depictions of the care setting offered by a number of care workers, during interview. Task-based activity and the initiation of contact with residents



according to the need to complete care tasks was reported to be a dominant influence upon relations between staff and residents, across all homes investigated.

"You can't always sit and talk all day long, can you, you've got to do your job as well." (rhjc17(f))

"Sometimes there's a lot of work to do and you don't communicate as much, or you communicate but it's very basic communication, until your work is done and you've got more time on your hands." (rhec16(f))

Such responses highlight an ordering of labour that operates in residential dementia care, echoing James' (1992) findings in this respect. Social interaction with residents therefore seems to be something undertaken by carers 'as well as' their job. It is fitted in between and around physical labour and appears secondary, even marginal, to what carers view as their work. While carers' accounts of emotion at work signalled their emotional investment, the occasions and opportunities wherein these attachments may be expressed and demonstrated appear constrained, compromised by the press of physical labour<sup>19</sup>.

### Constructions of embodiment

An attention to embodiment as a key feature of social experience has underscored the significance of the body to social divisions. As Grosz (1997) has argued, bodies are inscribed in a manner that upholds relations of power, the evaluation of bodies in medical science is imbued with an implicit norm that produces a corporeal hierarchy.

### The ageing body:

Oberg (1996) has argued that the body is silent and invisible in social gerontology. This silence seems paradoxical given that culturally, 'ageing is both experienced and presented visually through the body' (page 714, 1996). A social hierarchy exists in which differing

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<sup>19</sup> However, interview responses indicated that communication and physical labour were at times, interwoven. One to one care, particularly the provision of personal care, taking place within 'backstage' (Lee-Treweek 1997) areas of the care home, were identified as generating opportunities for interaction.



bodies register differing levels of worth and within this hierarchy the ageing body garners limited social value. Ageing is a process that 'produces' an unwanted and devalued form of embodiment. Care of the self, as attended to within discourses of consumption is one site where embodiment is constructed, according to market interests. In a study of discourses on ageing and embodiment within advertisements for skin care products, Coupland (2003) has argued that the ageing body is pathologised, with ageing presented as an 'unwatchable' process signalling the underlying ageism that informs such representations.

While advertising offers a site wherein certain ideologies of ageing are upheld it has also led to the emergence of alternative constructions of ageing. The targeting of older people as consumers of particular products and services has spawned some more positive representations. However, as Laws (1997) points out these images are "geared to a very particular embodied identity - an active, affluent, senior population" (page 97, 1997). In advertising, the older person as consumer is largely depicted as white, middle class and healthy, as such these representations of ageing carry an implicit message with regard to a hegemonic identity in old age.

The need to halt or slow the physical signs of age is also constructed as a gendered concern. Jagger (2000) has argued that the need to scrutinise body parts, based upon an experience of being both the subject and object of discourses of consumption, represents an important aspect of the 'work of femininity'. Embodied experiences of ageing therefore seem to differ according to gender, with women disproportionately incited to engage in bodywork in order to resist age. Through advertising, the older (female) body is constructed as marginal, positioned as outside the logic of an industry for which ageing represents failure.

The sequestered body:

Admission to residential care represents the physical removal of an individual from society, more often than not on a permanent basis, and their enclosure within designated places of containment. As previously noted such removal is often triggered by a perceived



deterioration in care of the self. The neglected or poorly attended body therefore serves to signify 'need'. In a study of hospice care, Lawton (1998) has drawn attention to the 'unbounded' nature of sick bodies as being a significant contributor to sequestration in hospices.

"Self-control has become mapped onto and experienced within the physical body as self-containment." (Page 136 1998)

Both Ungerson (1983) and Twigg (2000) have noted the association of such bodies with the low status of bodywork and care in society. Taboos associated with bodily waste and fluids are viewed as imbuing the status of those who carry out the work of tending to them. In a collection of studies of 'pariah bodies', Holliday and Hassard (2001) highlight the distinctions drawn between respectable and non-respectable bodies which form part of the establishment of social boundaries: 'bodies are frequently marked as in place or not in place' (page 12, 2001). The authors note the process by which unruly bodies serve to signify unruly subjectivity, highlighting the manner in which the twitching, jerking 'mad' body is perceived as a manifestation of psychological disorder.

It may be argued that care homes, like hospices, serve to uphold wider notions of appropriate or respectable bodies through sequestration of bodies that transgress such concepts. For people with dementia, the notion that transgression of certain social boundaries creates threat also appears to apply to conduct. According to accounts by family carers interviewed for the CPCEC project, behaviour perceived as 'out of place' represented a trigger for the consideration and explanation of sequestration.

"He didn't know people but he'd pretend he knew people and he'd embrace people he didn't even know, because he thought he was being friendly and nice, which was embarrassing to me but not embarrassing to him. But I would sort of lead him away gently." (r(f)rhel2(m))

"She's become institutionalised I'm afraid and I feel very sad. I'd love her to come to me but, you know, she'll put turkey in her shoe or she'll do the weird and wonderful things. Not that it worries me, but for her dignity". (r(f)rhel3(f))



## Embodiment and bodywork:

Wolkowitz (2002) has argued that differing workplace settings and types of bodywork have generated a range of ways in which the body is known. It is therefore important to look at the association between bodywork and place, the settings in which such labour is undertaken and how they inform the discursive construction of the body. Gubrium and Holstein (1999) argue that the nursing home represents 'a local culture of embodiment'. The function of residential care generates a ways of classifying and evaluating the body. The manner in which the body is framed by a discourse of decay and deterioration within nursing homes is contrasted to hospital settings, which are argued to construct the body according to the logic of recovery.

An attention to embodiment is therefore a useful means by which to gauge the local configuration of identities. Representations of the body, and the practices that stem from them, signal the manner in which the body itself is socially constituted - a situated construct.

## The medicalised body:

Care home documentation proved a site wherein the body was objectified via a medical gaze. Assessment and care plan headings fragmented the body through an attention to its parts and functions: "sleeping routines, eating and drinking, breathing, mobility, personal cleansing, elimination - urine and bowels, vision, hearing, teeth" (headings of the Standex documentation). This requirement to monitor the body, on an on-going basis, also served to present bodies in and across time.

Despite an overall inattention to the practice of bodywork certain aspects received formal recognition often signalling areas of organisational accountability. Thus, risk factors associated with moving and handling were addressed within the documentation as a reflection of the responsibilities that the care organisation held regarding the body of the care worker. Clear directives existed regarding the requirements for using either



mechanical lifting equipment or the input of two carers. Such requirements underpinned carers' discursive constructions of the body, classifying residents as 'singles' or 'doubles' and this, in turn, shaped bodily regulation. Thus, 'singles' would be assisted to get up, washed and dressed each morning before work commenced with 'doubles'.

#### The regulated body:

Tied to medicalised constructions of the body is the exercise and experience of bodily regulation within care homes. Residents' bodily functions were observed as under the control of the care worker, occurring according to a carer's schedule and workload with the experience or perspective of the resident often existing as secondary to this.

"I don't like washing them in the morning, getting them out of bed. I always say, when I reach their age, I want to be able to say what time I get up and you don't want to rush around. It makes them tired as well, rushing them, getting them out of bed, giving them a shower if they need it, getting them dressed, washing, it's not nice and it's very tiring for them." (rhec18(f))

Social and spatial divisions between carers and residents were also a significant indicator of how bodies served as the territory upon which power relations were inscribed. Twigg (2000) has argued that sharing bodily functions serves as a measure of social equality. Thus, the provision of separate staff toilets and staff eating their meals off-unit, heightened the differentiation between carer and caree.

#### The rules of touch:

Of the medicalised representations of the body a notable feature was the manner in which bodies were divorced from social identity. Thus, bodies emerged in care home documentation as asocial, set apart from a relational context. However, such a construct appears belied by the ways in which gender was found to mediate a great deal of the provision of care. Similarly, while the body of the care worker is attended to in specific



ways within the workplace, the gendered body of the care worker receives little formal attention<sup>20</sup>.

The presence of a gender boundary offers just one example of the manner in which gender structures the 'rules of engagement' between carers and residents, i.e. what happens between them and how it happens. Within the present study it was reported to relate particularly to bodily contact and the exposure of the residents body to the gaze of the carer. A gender boundary is also suggestive of a dynamic, in which the meaning that is ascribed to what happens between carer and caree is shaped by their gender.

In an investigation of the use of touch by nurses on an oncology ward, Perry (1996) found that male nurses used touch less and were more likely to use it instrumentally rather than communicatively. This was viewed as indicating that men are more inhibited in their use of touch. Perry speculated: "could it be that male nurses still do not have the same level of social permission as female nurses do?" (page 13, 1996). According to the findings of the CPCEC study, carers also employed touch communicatively. A large majority of respondents (23/79%), including all five of the men interviewed, reported that using touch and physical contact was an important or essential aspect of their work. A significant feature of many of these responses was an emphasis upon how touch can be utilised to convey an emotional 'tone', such as comforting and reassuring residents.

In addition to noting individual variation, amongst residents, as to how touch was received and perceived, two carers specifically indicated the manner in which gender mediated the use of touch.

"In our culture, we don't touch men, never cuddle them, I change over the years. First time I went to the hospital, the Jewish home to help one of them just for part-time, she put him to bed and kiss him and when I saw I thought 'ooh', what is it, you know, in my culture you never ever. But now I can kiss them within the proper, you know, you understand what I am trying to say yeh? I can touch them and can cuddle them and this is changed." (rhec9(f))

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<sup>20</sup> As will be discussed in the following chapter, this is despite the potential vulnerability of carers, for example when cross-sex episodes of care are sexualised by care recipients.



"I suppose it's because I'm a woman, if women do, a woman feels as though they can give a woman a hug, it's natural. But a woman, if she gives a man a hug it's not really, you know, natural, you do, but it's not the same." (rhfc23(f))

Comparing interview responses to video-taped data, there was a consonance between reported use of touch and that observed. Both male and female carers were observed using touch communicatively during interactions with carers. However, while few carers mentioned the instrumental use of touch and physical contact this emerged from video data as the most common form of touch employed. Another finding, emerging from video-taped data was that residents' bodies were 'zoned' according to the gender of carers. Male carers were observed to touch the face and head of residents while carrying out care tasks, for example when shaving (both male and female) residents, however at no time were they observed touching residents' faces or their heads as a form of expressive touch. This contrasted markedly with the use of touch by female carers who were observed touching the faces of residents, taking their heads in their hands and stroking the cheeks of residents while communicating with them. Thus, rules of touch were in operation during interactions between carers and residents and these appear to be shaped by gender.

The body as territory:

An integral feature of the bodywork carried out by carers was bodily presentation. While tending to the bodies of residents as the object of care, carers were also required to 'present' residents, undertaking grooming, dressing, the application of make-up and generally attending to a resident's appearance. Gendered norms appeared to mediate this aspect of carers' work. Within interview data the social presentation of residents' bodies emerged as a significant and, at times, contested aspect of care work. A resident's appearance served as an indicator for the quality of care of which they were in receipt but also as an indicator of their subjective experience and condition.

"While there is interest in the condition of the body in its own right, the body is widely monitored for what it tells in relation to a gamut of related institutional concerns." (Gubrium and Holstein, 1999, page 520)



In a study of the institutionalised care of older people, Reed-Danahay (2001) found that nursing assistants placed emphasis and importance upon the physical appearance of residents, competing with one another in having their residents 'looking good' and through this generated a sense of pride in their work. Lee-Treweek (1997) noted that the physical state of residents in care also provided the means by which charge nurses could judge the work undertaken by nursing assistants.

"Not only the cleaning and dressing of the patients but also the creation of some semblance of gendered normality, through dressing, applying make-up, combing hair and putting in dentures." (Page 53, 1997)

Interviews conducted with the next of kin of residents for the CPCEC study, highlighted the manner in which appearance served to signify, to them, both good care and the well-being of the resident. The body was therefore a barometer of care and a means for evaluating it.

"He was more unkempt at (previous home) than he is here. He's nicely dressed here and he looks comfortable so I wouldn't want to change it, I don't think there's any need to change". (r(m)rha1(m))

"She always seems quite well turned out and, you know, clean and we go up there, upstairs sometimes and you've got some clothes hanging on the wardrobe door and you know that somebody's going to come and dress her shortly. I think she's quite relaxed and contented. She'd rather be somewhere else, but doesn't realise the realities of being somewhere else." (r(m)rha3(f))

These responses to questions seeking to establish how families viewed the care provided in homes demonstrate an association between outward appearance and internal states. Relatives' responses also echoed Lawton's suggestion of an association between self-control and self-containment when judging subjectivity according to bodily states:

"Mum's always dressed nice, she's always spotlessly clean, she doesn't smell."... "I have talked to the staff about this and they said that she's a very, very clean person, although she can't ask to go to the toilet she very rarely soils herself during the day. And they say if you're feeding her with tea or something and she gets dribble



marks, she doesn't like food round her mouth and she tissues it away herself." (r(f)rhc8(f))

Appearance was also contextualised according to a biographical narrative as presented by relatives. The look and appearance of residents could therefore either uphold or disrupt a biographical narrative, according to the perceptions of relatives.

"It's just that he was so immaculate, oh, he was always so prestigious. He was always beautifully dressed, beautifully turned out, spotlessly clean, impeccable." (r(f)rha0(m))

"I don't believe anybody ever goes through the wardrobe to see if anything needs cleaning or washing. Maybe that's just an impossible thing because it's not a hotel. But there are times when I come to see her and she's wearing clothes that are dirty, stained, very often I take clothes home." ... "As a child I don't ever remember ever seeing my mother at any time not made up. And to this day, if I'm talking to her today she'll ask 'do I need lipstick?'" ... "I don't know whether or not her carer is actually conscious of dressing her in a given style. I don't think that happens at all. I don't think anybody thinks 'oh, we'll put this coloured cardigan on because she's wearing that colour'. I don't think anybody does that." (r(m)rhc9(f))

This last response also highlights the body as a contested territory. The son is critical of his mother's presentation according to his own narrative of her biography and gendered identity. The perceived failure to present his mother adequately thereby contests the home's claim to authority over his mother's body. Carers themselves also offered insights into how residents' bodies mediated such tensions.

"When we have difficulties is when people will, for example' ... 'expect their mother made up to the 99's when she looks like, you know, she looks totally and utterly ridiculous or fights the staff when they put the make up on or whatever, it is what the relative wants. You may think it is ridiculous but it does happen, where a daughter will come in and shout abuse because her mother hasn't got her eyeliner on. I can understand why because, perhaps this is what mother has done all her life". (rhc21(f))

Residents' bodies were also the site for the expression of familial tensions and, at times, it seems it was necessary for carers to negotiate these tensions as an added component of their emotion work:



"I had a very bad time with my Mum's brother, who said there's nothing wrong with her. He came, barged in here and said she hadn't had glasses for 15 years, she's got rubbishy clothes." ... "Here they had to put up with him and the friction between us, you know 'I want to take her home to have new glasses', let me tell you she had these glasses in the summer, this was a couple of months later. And 'I want to pay to have her teeth done' well don't you think we'd have done that, but she won't let the dentist anywhere near." (r(f)rhel4(f))

Reed-Danahay's (2001) finding that carers generated pride and self-esteem from bodily presentation while competing with other carers in this area of their work were echoed in responses generated by the CPCEC study. One of the carers interviewed signalled her unhappiness following the transfer of a key-worked client from one unit within the home to another.

"When I go down there, her hair is looking so stringy and everything. Every morning, everyday, most of the morning I come in, I try to shower my residents and wash their hair, blow dry it, set it and everything. I go down there and look at her, she's a completely different person." (rhec18(f))

This response suggests that bodywork may reflect an emotional investment in the relationship between carer and caree, wherein the work of bodily presentation represents the interweaving of the 'caring for' and 'caring about' components of care.

The finding that presentation served to inform judgements of care for families and to demonstrate a quality of care performed by carers suggests that the meaning it holds for residents themselves is marginalised, highlighting the limits placed upon residents with regard to claiming authority over the territory of their own bodies.

Within these responses, and integral to the issue of the body as a contested territory, is the maintenance of a gendered identity and the perceived success or otherwise in achieving this. Both relatives and carers described how the maintenance of a 'gendered normality' is 'done to' residents, it is performed on them for a number reasons. Bodily presentation, mediated by gender, serves to uphold biographical continuity according to narratives constructed by carers and relatives. It serves to demonstrate, to families, that care is being



provided and being provided well. Significantly it also serves, for relatives, as a marker of the feelings and subjective experience of the resident in care often in circumstances where communicative impairment and short-term memory loss preclude or compromise the potential for directly eliciting this from the individual concerned.

### The body in care: Conclusions

This study suggests that an inconsistency exists wherein the medicalised discourse that structures the provision of care is silent regarding gender, despite the fashion in which gender serves to pattern bodywork and caring relations. There seems to be an absence of any notion of a gendered client within the dominant medical discourse operating in care. The bodies of residents are fragmented and objectified while under constant surveillance by care workers. And yet, in their engagement with the bodies of residents, carers both observe and uphold gender norms and gendered identities.

Emerging from this analysis and attention to the body in care are a number of dimensions of gender. The body serves as a locus for an interaction of ageing and gender. Changes to the body highlight the fluid nature of gender. Individuals are positioned and treated differently over time, according to this process of change. The evocation of an ideal body within consumer discourses, alongside dominant notions of the body as controlled, contained and bounded contribute to the construction of a hegemonic body. Ill, disabled and ageing bodies are measured and evaluated according to such hegemonic embodiment.

Another dimension of gender identified within dementia care is the manner in which it may be done to a person. The gendered aspects of presentation, as performed on the bodies of residents, represent a collective exercise, through which an individual is made to approximate a gendered norm. Maintaining a gendered 'normality' in the presentation of residents served to reassure relatives according to a logic of biographical continuity. The body is a surface from which a subjective experience of care is read. It also serves as the site for negotiating claims upon an individual by various parties. This negotiation raises



the question of, for whom such presentation work is carried out, and what association this work holds with the needs or perspectives of residents themselves.

The touching and handling of bodies is also mediated by gender. Rules apply as to who may touch whom. The body in care was found to be 'zoned' according to gender and this highlights both the gendered rules of touch but also the presence of a gender dynamic. That comparable types and levels of touch may be ascribed differing meaning according to gender may be considered of particular importance in the construction of that which is deemed transgressive within care settings.

### The care dynamic (part two) - Bodily communication

The communicative and cognitive impairment characteristic of dementia may be understood to heighten the significance of the body in care as it often serves as a barometer of subjective experience. Bodily communication is therefore of particular consequence to an assertion and expression of self. Indeed, for those people with dementia whose capacity to express themselves clearly through speech has diminished, bodily communication represents one of the few avenues through which they may make an active social contribution. Occasions when residents physically resist the provision of care thereby represent another level at which the differing agendas of care workers and residents are negotiated.

As previously noted, a number of studies investigating aggression in people with dementia residing in care have reported an association between male gender and aggressive behaviour (Eustace et al 2001, Lyketsos et al 1999, Matsuoka et al 2003, McMinn and Hinton 2000, Ott et al 1996). These studies, notably underpinned by a medicalised model of dementia, according to which aggression is treated as a disease symptom, focus upon treatment. In some cases, evaluating the efficacy of particular regimes of medication. While masculinity is presented as a predictor of aggression, aggression itself is treated as an unproblematic category, attended to according to its presence (often as reported by care workers) without consideration of the circumstances in which it occurs.



The finding that male gender is associated with aggression may be taken as an indication that aggression is a response more commonly employed by men in receipt of care. However, this finding has not been replicated across all studies, with a number of investigations reporting no association between gender and aggression (Gormley et al 1998, Aarsland et al 1996). As an indication of an underlying biomedical model of dementia, across this body of studies aggression is treated as a discrete behavioural symptom, rarely is it considered to be co-produced, or as the product of an interaction.

A study by Foley (2003) asked dementia care unit staff to identify their most disruptive residents and give examples of successful and unsuccessful interventions. The study found what was described as a 'big man syndrome' in which the physical size and strength of some male residents, deemed physically aggressive, was identified as a particular concern for staff. The four 'big men' identified by staff were discharged from the care homes in which they resided. The study concluded:

"Residents' size and strength emerged as a risk factor for lack of successful behaviour management." (Page 121, 2003)

A study by Bridges-Parlet et al (1994) of physically aggressive behaviour (PAB) made use of observational techniques within long-stay care environments. It was found that most cases of PAB occurred as a result of intrusion into the subject's personal space by staff or other residents. The study concluded that PAB is better understood as a defensive reaction than as an expression of anger.

An interesting dissonance within the data generated for the CPCEC project was that aggression was given particular emphasis during interviews, by care workers, whilst few occasions arose when aggression by residents was observed during fieldwork or recorded within video data. Nearly all the carers (94%) interviewed offered accounts of experiences of aggression by residents. A notable feature of these accounts being the portrayal of such incidents as unpredictable, unprovoked and as an outcome or symptom of dementia. Residents were described as 'lashing out', being 'spiteful' and 'moody'. Aggression was



cited as a reason for having poorer relations with some residents than others. These accounts also highlighted the vulnerability of carers, the frequency with which aggression was referenced during interviews suggesting it was viewed as a particularly challenging aspect of dementia care for many workers.

"I'm not being nasty but he'd be just like a crazed animal really you know, he'd be like an animal let out of his cage. He used to kick out, thump, scratch, bite everything and you couldn't do nothing for him." (rhlc30(m))

As noted previously a number of carers cited the strength of male residents as a reason for increasing the numbers of male carers. Three of the thirty care workers, who spoke about experiences of aggression with residents, indicated a perception that men were more likely to be aggressive than women, thereby echoing the findings of existing research:

"Some of the men are very aggressive here, they are very, very aggressive which you can't compare it with the women. The women you wouldn't have any problem, some of them when you go there straight off they know what you are coming to do". (rhec19(f))

Within care home documentation, 'aggression' was present as a decontextualised label in residents' care plans and files and presented as a disease symptom. It was also a label that was applied to both men and women. Within the present study, references to 'aggression' were noted in the files of five female residents:

"Light sedation prescribed because of aggressive behaviour." (Care plan for rha3(f))

"Can be aggressive towards staff because of Alzheimer's." (Care plan for rhd11(f))

Such labels may be understood to alert care workers to the potential for aggression in a resident but may also be understood as contributing to their reputation within care home environments. On the few occasions when aggression by residents was observed or filmed it occurred during the completion of care tasks, largely as a response to an imposition by care workers and particularly to the use of physical force and restraint by carers (see



Appendix 8, for a transcribed example<sup>21</sup>). As such, aggression during episodes of care may be understood as co-constructed, highlighting the dynamic quality of care.

Aggression was therefore often a direct outcome of 'enforcement' - the choice by care workers not to respond to the will of a resident by desisting from a particular task. This suggests the value of understanding aggression as a defensive reaction rather than an expression of anger (Bridges-Parlet et al 1994). The level of aggression employed by residents appeared to be associated with the level of restraint placed upon them. The strength of a resident as matched to that of the care worker was therefore clearly a factor in these episodes of care, offering an insight into how a 'big man syndrome' may emerge.

An unqualified association of masculinity and aggression therefore appears problematic. On the infrequent occasions when aggression occurred, it appeared to be reactive and thereby predictable, a product of the use of force and restraint by carers. There is a need to consider the interactional dimension of occurrences of aggression. Questions also arise as to the ethics of treating aggression as an unproblematic category, often based upon care workers interpretations, not least when this label informs the use of sedative medication. A label of aggression is likely to shape the manner in which a resident is treated and serves as a significant feature of their reputation within care, with gender often mediating this.

## CONCLUSION

This chapter has set out to explore how ways of seeing produce ways of knowing care. The investigation has been framed by a consideration of the distinct characteristics associated with formal care provision. The methods for generating data within the CPCEC project were a key factor in achieving this. Video data has provided the opportunity to explore care as a dynamic and interactive practice, a dimension rarely addressed in existing discussions and investigations of care.

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<sup>21</sup> Of particular note was the disparity this episode revealed between the spoken input by care workers and their physical enforcement of the care task.



Triangulation of data has also proved fruitful in developing a more comprehensive model of care and the relevance of gender to this. A consideration of interview responses alongside video data has demonstrated various aspects of the experience of care that are particularly inaccessible to observational techniques, while these accounts of care have been open to comparison and contrast with filmed events and interactions. Accounts by carers of how it feels to provide care proved valuable in disentangling what has previously been argued to be a confused and often unclear debate on emotion in care work. They also highlight aspects of emotion work that may be specific to caring for people with communicative impairments and how the reading and interpretation of emotion states maintains the social inclusion of people with dementia.

Carers' accounts have highlighted a number of rarely addressed aspects of formal care that bear comparison to reported experiences of network care. The presence of a personalised contract that carers import into their work highlights the sense of commitment and the bond they enjoy with residents and this may be understood as echoing the felt obligations and commitments that informal carers have been shown to observe when undertaking familial care. Of particular note has been the identification of a notion of ideal care present in the narratives offered by carers, which has underscored the disparity between that which carers are compelled to do and what they would wish to do. The inherent tensions within a dichotomy of actual and ideal care touches upon a crucial and as yet largely overlooked aspect of the experience of providing paid care.

#### Gender, communication and care:

This chapter has aided an understanding of the ways that gender operates interactionally. Thus, it has been argued that gender is frequently referenced during care, called into service in order to achieve particular ends. It is important therefore to consider the ways in which gender is made salient in caring encounters and what purpose this serves. Gender was also found to structure care encounters, providing the 'rules of engagement' at both a verbal and non-verbal level. An attention to babytalk in care also signalled the ways in which care 'scripts' are invoked and the importance of gender to this. This finding



contributes to a wider understanding of how gender provides the tools for undertaking care<sup>22</sup>.

This study has also demonstrated that the body is a primary focus and territory for the provision of care. As such, there is a need to incorporate an awareness of the gendered body into an understanding of caring encounters and to consider the ways in which constructions of the body are upheld through interaction. Gender was also found to be an integral dimension of the dynamic between provider and recipient of care. This dynamic may be understood to inform interpretations as part of a wider process of attributing meaning to care encounters. A particular question this raises is whether like situations earn a different meaning according to the gender of interactants. For example, as previously discussed, it appears that personal care is viewed as more or less acceptable according to the gender of both the recipient and provider. Overall, these differing dimensions of gender at an interactive level underscore the negotiated and fluid quality of identity and represent a challenge to notions of gender as a fixed and stable factor when investigating care.

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<sup>22</sup> For example, in relation to the provision of personal care in informal care situations, Arber and Ginn (1995b) have argued that a nursing or mothering 'role' is likely to be more readily assumed by women than men, when caring, in order to overcome a cross-sex taboo.



## 9. INTERACTIONS - PART TWO

### Introduction:

This last chapter of analysis will develop further a consideration of gender in context through an attention to place, space and time. Far from serving merely as the backdrop to social relations it will be argued that space and time actively interact with identity, and must themselves be considered socially produced. Thus, mapping the landscape of dementia care provides an avenue to demonstrating the 'situatedness' of gender. A place in time, and time in place, are experienced through identity and a particular concern for the present chapter will therefore be the manner in which gender produces certain experiences of place. In continuation of the theme of identity in place, this chapter will explore the situated construction of identity. It will be argued that particular social settings provide localised resources that serve to uphold identities and are the means by which meanings and worth are attached to identity. A trajectory through time, and from place to place, highlights the fluidity of gender, leading to an experience of what might be described as 'gender mobility'.

Massey (1997) has placed emphasis upon the fluid nature of place, arguing against conceptualising place in terms of holding a single or coherent identity. Rather, the variety of differing experiences of any given setting suggest that it be better understood as full of internal conflict and variance. Thus, fieldwork for the present study highlighted a disparity in the experience of time and place for care workers and residents, within care home settings. The time-limited presence of care workers was regulated and structured according to a workload of set tasks. The press of workload reportedly led to an experience of time as often insufficient. A perceived lack of time was repeatedly cited during interview as a significant obstacle to the provision of what carers indicated was 'ideal care'. In contrast, a sense of time abundance in residents' experience of the care setting was noted by care workers, a number of whom identified a lack of activity and boredom as common features of residents' everyday experience. These disparate



experiences of time and place may be understood as a key social division between workers and residents.

### **Identity in Place: Part One**

Ley (1996) has argued that while place holds meaning for a subject, that subject also has meaning in place. This relationship alters between places and over time, with factors including the degree of environmental control an individual is able to exercise mediating opportunities for self-expression. Laws (1997) identifies retirement as a key moment when associations between identity and place are reconfigured. In leaving behind the workplace, residential environments and spaces associated with leisure take on a more central meaning in the lives of many older people. As such, Peace (1993) argues that home may be considered a power-base for older people. Place may usefully therefore be understood as a crucial component of the negotiation of power and control for older people in receipt of care.

### Dimensions of home

#### Gender and home:

Investigations of the meanings attached to 'home' provide a particularly apposite example of how gender has been argued to produce experiences of place and space. However, the 'genderness' of home has been explored specifically in relation to femininity. Very limited attention has been given to an association of masculinity with domesticity (Francis 2002). What home means to men and how it interacts with masculine identities are issues that arguably take on particular relevance in later life when, as Mowl et al (2000) point out, men's relationships with the homespace are subject to considerable renegotiation. The notion of masculinity 'at home' is currently under-explored, and in many ways men are considered to be out of place when in a domestic setting. As previously noted, this point is illustrated by the use of male subjects in domestic settings in Jewish Care fundraising



advertisements. The image of an older man, home alone, may be argued to provoke anxiety, even guilt.

Far greater attention has been paid to women at home, indeed it has been argued that the domestic sphere is a site that mediates constructions of femininity:

"Homespace is shown to be inscribed with specific visions of woman, to define women, and to do so in relation to and through the work of domestic labour which takes place within the house, that is through the tasks of social reproduction."  
(Gregson and Lowe, 1995, page 226)

Peace (1993) has argued that ideologies of gender have played a key role in the design of residential environments. The stereotype of the nuclear family has shaped housing design and provision, making concrete a range of assumptions relating to the gendered division of labour. In this way, hegemonic versions of masculinity and femininity are supported materially and spatially.

It has been argued that the home represents a site and source of oppression and exploitation for women, leading to social, material and economic disadvantage (Oakley 1974). Gender inequalities are expressed through a gendered division of labour within the home and are upheld at a social and symbolic level through wider associations of femininity with a duty and obligation to care (Finch, 1989). Domestic confinement is compounded by the social and physical exclusion of women from public settings and spaces (Women and Geography Group 1984). It has also been argued that the home represents a power-base for women and a site of feminine authority and resistance (hooks, 1991).

However, certain versions of femininity often underpin explorations of the associations between women and the domestic sphere. To date, far less consideration has been given to how such arrangements change over time, how the meaning of home may alter as people age and how gender relations in the home may be reconfigured according to a variety of changes associated with age. It is therefore clear that gender and ageing must be



understood to connect in place and that gender and place connect differently according to age.

### Ageing and home:

The meaning that home holds for individual clients and the significance to them of residing at home has little observable influence upon community care policy and legislation. In a study of experiences of relocation for older people entering residential care, however, Reed et al (1998) highlighted the connection for many of their subjects between a place of residence and a sense of self. Home was found to serve as a site around which networks of both concrete and imagined associations were developed.

The home offers opportunities for an expression of self through its design, arrangement, contents and use of space. A study of older people's relationship to home by Mowl et al (2000), found that many female respondents viewed a tidy home as indicating an occupant who was fit and had visitors while an untidy house was seen to suggest that the inhabitant was isolated, frail and unable to cope. Interview data from one CPCEC project participant, attending day care (and soon to enter residential care), highlighted the manner in which a sense of self was tied to the homespace:

"People would say 'oh this looks a nice room' and that was me they were talking about, not the room, so I did like it I really did like it." ... "It had to look good, I knew just how it had to look, I had to be in it to feel it was looking good, you know, and it was a nice feeling that you'd done that for it." ... "I'd know how to move things around and make them look as though they were worth having, you know. And I'd make it look nice you know and that was another thing, you had to make it nice you had to make it inviting."

### The changing nature of home:

Sixsmith (1986, 1990) has argued that ageing may lead to the 'coming into consciousness of home' (page 191, 1990). It is argued that at both a symbolic and instrumental level the



home represents a site wherein independence may best be preserved. Thus, time and place interact with changing identities leading to a fluid experience of home.

For older people in receipt of care and support, home-based responsibilities and activities are transferred to care workers and other family members. Kellaheer (2001) notes that this loss of independence and autonomy may impact differently, according to gender. Baker (1993) has highlighted the gendered division of labour regarding much activity in the home associated with the upkeep of an observant Jewish lifestyle. Thus, physical or cognitive impairment and disability are likely to undermine the maintenance of cultural identity in a manner that impacts differently according to gender.

A fluid and changing experience of home may be heightened for a person with dementia, as over time a domestic setting becomes an unfamiliar space through memory loss.

“There’s this lady, I see her twice a week, and she says the same thing, you know, that she wants to go home and I’m saying ‘well, this is your home’ and she says, well, she can’t find her way home, so she’s lost, you know”. (Home care worker interviewed for the CPCEC Project)

The importance of home to life in care:

Placement in care entails a consequent displacement from home, with gender arguably of particular relevance to this experience. As such it is useful to consider experiences of care through experiences of the loss of home, given the argument that subjects have meaning in place.

Prior studies investigating adjustment to institutionalised care for older people have identified differences, according to gender, associated with satisfaction and well-being in residential care facilities (Claridge et al 1995, Joiner and Freudiger 1993). Evers (1981) and Hockey (1989) have argued that admission to residential care has different implications for residents, according to gender.



"Most of the women found themselves bereft of their identity as domestic carer. The men not only experienced continuity in receiving care from women, they also discovered new scope for public 'role-playing' once they moved out of a more private form of domestic life." (Hockey, 1989, page 209)

According to these studies, admission to care may uphold or disrupt biographical continuity according to a gendered divide of the public and private. The accounts offered of transition to care thereby rest upon a notion of gender as in or out of place. This organising logic appears to overlook the prospect that meaningful feminine identities may exist within a public domain or that masculinity may be upheld within a domestic setting.

For the present study, 32 care workers and six non-care workers were asked whether they perceived residents as coping differently following admission, according to gender. It was in the responses to this question that an association of gender and place was given particular emphasis. Of the care workers interviewed, 12 (38%) respondents indicated that differences in coping were related less to questions of gender and instead were based to a greater extent on individual attributes relating to health and prior social histories and experiences. However a majority of carers ( $n = 20/62\%$ ) indicated an impression that residents coped differently according to gender and a number of contrasting explanations were offered as to why this might be. Twelve (60%) respondents felt that women coped better than men, in contrast to findings from existing studies. For non-care workers, all six of whom were female, four respondents saw gender as an influence upon how well residents coped in care, two of whom suggested that men coped better while two suggested that women coped better.

Eight carers and three non-care workers noted the importance of home and of the prior relationship to home, including responsibilities within it, as a key influence upon how well residents coped when admitted to residential care. Coping following admission was therefore judged according to a notion of how well the care home environment facilitated a degree of biographical continuity in relation to gender in place.



A number of respondents viewed admission to a care home as less disruptive for men, on the grounds that their identities were perceived as less directly tied to the home. Interviewees suggested that men's experiences of being catered for (personal services) within the home prepared them well for accepting care following admission. A perceived lack of ability or practice in self-care when at home was also cited as a reason why men benefit from admission to care.

"I think the male (residents, cope better), because if it's the female, most of the female when they're at home, they are the one looking after their husbands. I mean domestic wise." (rhec11(f))

"Because men like to be waited on, most of them have been waited on all their life, if it's not their wife, their daughters, whatever. Where women don't get waited on so much." (rhenc2(f))

"Basically, in these residents' past, the wife did everything and consequently if the man loses his wife, he has problems. Whereas if the wife loses her husband she carries on. I find that men are perhaps worse at taking care of themselves, but I think things are changing. I don't think men function as well as women, in that generation, women did everything for them." (rhanc1(f))

A lack of association with the home or of meaningful activity within it was also perceived by some respondents as leading to men coping less well in care.

"Maybe because in those days, because residents are coming now in their 90's, 80's, men are more, have more power with money and stuff like that, even though the woman used to keep house and things. But the women seems to, you know, they make their bed, or they do bits of things that they would do anyway at home. Men feel as though everything is taken away from them. They've got no power any more with their money and stuff. I don't know I find that women cope better, I don't know if there's any kind of theory to it." (rhbc5(f))

" I think women cope better because they are still like the head of the family. There's this eliteness and the men are somewhat suppressed in an environment where 99% of the people are women." (rhjc29(m))

The association of femininity with the home and the closer ties that women were perceived to have with activities within the home were viewed by respondents as



underpinning both an ability to cope better than men upon entry to care and conversely, as reasons for coping less well.

"I think women on the whole are more adaptable, they sort of have to adapt their lives to fit around lots of different things, especially if they have children, they seem to adapt quicker, yes." (rhlc15(f))

"Men settle in better than women because a woman's work is never done (laughs), it's as simple as that. A woman's always had a role, men do take the backseat in home life and after all they are coming into a home, there isn't a lot for a man. But when you think of what a woman will do throughout her day, just being in the home without going shopping or anything, the silly little things, getting out of a chair and washing a cup. That is all taken away from them." (rhenc2(f))

According to the perceptions that both care and non-care workers have of how residents cope and settle in residential care, a number of dimensions of gender and place interweave to produce experiences of displacement. A gendered division of labour, gender relations within the home and the association of home to a gendered identity were all indicated as influencing residents' experiences of admission to care. Arising from this data is the question of how the relationship of gender and place is reconfigured following entry into care and of what opportunities exist for both male and female residents to maintain a sense of self following displacement from home. Interview data suggest that, according to the perceptions of care home workers, prior relationships to the home have a defining influence upon experiences in care, for residents. The degree of variance in responses from interviewees signals the range of perspectives upon how gender produces experiences of the care home that may either uphold or undermine biographical continuity. As proxy accounts of the experiences of residents, the data provide an insight into respondents' own beliefs and attitudes regarding gender in place and the manner in which they are positioned to read residents' experiences through such beliefs.

At a discursive level, space and place therefore appear to organise representations of gender. These findings underscore the perceived associations between gender and home and how this serves to organise accounts of life in care. Women's association with the domestic sphere and a contrasting disassociation of men from the home appear to be key



influences upon how care workers evaluate residents' experiences of coping with admission to care.



## **Identity in Place – Part Two**

### **Maintaining Personhood:**

As noted previously, a theory of Personhood has been developed in relation to experiences of dementia that has placed emphasis upon the collaborative process of maintaining a sense of self (Kitwood 1997). However, the manner in which gender may imbue this process and the possibility that Personhood may be maintained in gendered ways has received little consideration.

In the development of a fluid and relational notion of gender there have been a variety of attempts to encapsulate the manner in which a gendered identity is socially achieved.

"Gender scholars have used diverse terms to represent gender dynamics - doing gender, gendering, performing, asserting, narrating, mobilising and manoeuvring - each tries to capture gender in practice." (Martin, 2003, page 351)

Such notions of the practising of gender appear relevant to a consideration of how a sense of self is upheld. They suggest a view of identity as enacted through repeated practices that, at both a personal and social level, are recognised or intelligible as gendered.

In a study of older people's experiences of transition to residential care, Reed et al (1998) have highlighted the importance of attention to the 'salient resource environment' (page 864, 1998). These salient resources are the aspects of an environment that are of most relevance to the maintenance of identity according to residents' previous lives and biographies. As noted above, this perspective was echoed by some care workers in their accounts of the manner in which care settings either supported or compromised the continuation of activities and responsibilities associated with a gendered experience of home.

### **Spatial regulation and environmental resources:**



During fieldwork for the present study, opportunities for residents to maintain a sense of self through an engagement with salient resources were restricted at two levels. Few personalised belongings or resources were readily available to residents. Additionally, in their interaction with care workers, residents were observed as further restricted in their access to the limited resources that did exist.

A number of existing studies have highlighted the social and material losses that characterise admission to care. Schmidt (1982) has argued that many of the resources that may facilitate a degree of autonomy and enable an individual to exercise leverage are lost following entry to care. Similarly, Hockey (1989) has argued that entry to care represents the shedding of personal possessions, responsibilities and personal space. A resident subculture has also been argued to regulate how residents engage with their environment, shaping notions of appropriate conduct:

"Residents are most reluctant in the public arena to distinguish themselves from the collectivity by appropriating space or objects or by undertaking such ordinary tasks as watering the plants." (Kellaheer, 2001, page 224)

Upon entry to care, many residents are restricted to bringing with them a small selection of belongings. To date, little consideration has been given to the significance to residents of the possessions they import into care. Neither has there been an exploration of variations in the nature or meaningfulness of these belongings according to factors such as gender. Diary entries and video data generated for the CPCEC project highlighted that residents' personal possessions were largely contained within their rooms with few belongings, other than handbags, accompanying their transfer to communal day rooms each day. As such, residents spent a large portion of their day separated from this small but personally significant selection of belongings. During the periods spent in day rooms, a very limited range of material resources were available to residents that might be considered facilitative of social exchange or supportive of a social identity.



Rarely were residents observed as encouraged to engage with their environment in an autonomous fashion. They were required to wait for meals and drinks to be served to them, and were barred from entering kitchens, laundry rooms and offices. On some units, the doors to bedrooms and/or the doors leading in and out of the communal areas were locked or in some way secured throughout the day.

"We have had cases where people are what I call 'wanderers' and they want to escape, maybe escape seems the wrong way of putting it, but they don't want to be in." ... "I know it's their choice if they want to go out but also, when they're in a home they're the home's responsibility." (rhfc23(f))

Residents were required to be in certain places at designated times and their movements within the care setting were closely monitored and restricted. This spatial regulation appeared to be associated with the exercise of panoptic control by care workers. Residents' movements were constructed as in or out of place according to the regime of the care home. Frequently, carers were observed to maintain a turn-taking order, for example with regard to assistance to use the toilet. In this way, requests for assistance from residents were sometimes deemed out of turn.

Existing research has shown that carers use deflection to avoid the disclosure of painful experiences by older people in care, thereby more efficiently completing care tasks (Grainger et al 1990). Video data generated for the CPCEC project revealed that deflection was employed by carers at a wider level while undertaking their work and was achieved at both verbal and non-verbal levels. The use of deflection led to care workers maintaining an efficient completion of care tasks, however the social outcomes of this for the residents seemed to be overlooked.

Across all the homes visited during fieldwork, deflection served to maintain both a spatial and social division between care workers and residents. Care workers regularly deflected offers of help by residents, for example when preparing or serving food or drinks (see Appendix 9 for an example). This use of deflection served to maintain a social order in which clearly defined roles of serving and providing and being served or provided for



were upheld. Unsuccessful attempts by residents to become involved in the daily workings of the home demonstrated how a lack of environmental control inhibited engagement with salient resources (i.e. the props and activities that might potentially support biographical continuity).

Despite the availability of a variety of 'salient resources' within each home, their potential to support a sense of self was undermined through the maintenance of a socio-spatial divide. A key feature of this divide was that it appeared to apply to all residents irrespective of individual capacity and functioning. This 'over-accommodation' (Wahl 1991) therefore constrained potentially identity-supporting practises and highlights a further inconsistency of the care regime. That many such practises may be understood as gender marked or as supporting the continuity of a gendered biography was an issue that many care workers perceived as a key factor in coping with the transition to residential care. There appears to be a dissonance therefore, between this reported recognition and the practice of care.

#### Interactive resources:

Another important source of social resources available to residents existed at an interactive and associative level. Despite the undoubted significance of this aspect of life in care there is currently limited research investigating the 'sub-cultural' relations between people with dementia.

McKee (1999) argues that there is a need to both explore and better understand the social lives of people with dementia outside of a constant reference to carers and carer activities. Similarly, Reed and Macmillan (1995) have argued that an emphasis upon carer-caree relations within studies of care settings has overlooked the significance of resident friendships and their influence upon how social identities are negotiated and maintained. As Hubbard et al (2003) have argued this oversight is particularly marked in relation to people with dementia residing in care.



“There has been very little study of the ways in which residents with a cognitive impairment seek each other and socially interact.” (Page 101, 2003)

The demographics of dementia care may be considered an important influence upon opportunities for establishing friendships. According to the video data generated for the CPCEC project, a clear pattern of friendship and association, noted across all the homes visited was an observed preference for same-sex friendships and interaction. Of those project participants who were observed to maintain friendships and to spend time in the company of specific friends (n. = 6), only one chose to socialise on a regular basis in a cross-sex friendship. For those participants who were unable to mobilise independently, opportunities for maintaining friendships were further constrained and decisions as to where they sat in day rooms largely the responsibility of care workers with little observed consultation as to seating preferences. As such, care settings may be understood to impose coupling constraints upon residents that are further compounded by disability.

Care workers perceptions of resident-resident interaction:

For the CPCEC project, care workers were asked to comment upon their perceptions of interaction between residents. Of 25 classifiable responses (n.7 = information missing), seven (28%) interviewees reported a perception that interaction levels between residents were low. While three (12%) carers perceived interaction to be largely positive, a further 15 (60%) carers, reported a mix of both positive and negative interactions, noting the presence of both supportive friendships and conflict.

Interviewees were also asked to describe their impressions of interaction between people with dementia and the wider population of residents. Of the 24 classifiable responses, (n.8 = information missing), eight (33%) respondents again reported relations to be mixed, noting that while some residents offered support and understanding to confused residents, others displayed intolerance and a reluctance to interact. Three (12%) carers highlighted a perceived social segregation between people with dementia and the wider population of the home. A further six (25%) respondents offered examples of stigmatising reactions and treatment towards people perceived as confused.



Of the six non-care workers interviewed, three indicated a perceived sense of intolerance by cognitively intact residents. Respondents reported observing incidents of stigmatising treatment of residents with dementia.

"They seem to be segregated and the residents don't like to involve themselves with them, I don't know why, well, if it's (because) they're scared that it's going to happen to them.' ... 'You get some people sort of 'I won't sit next to her' or, you know 'that lot's come down' or something like that. It seems very like discrimination really, I suppose". (rhjnc6(f))

Of particular pertinence to the present study is a consideration of the ways in which gender may be considered to influence the establishment and maintenance of friendships in care. Across a wide body of research addressing gender and communication it has been suggested that gender influences how individuals interact and the communicative resources that are accordingly developed, across the lifespan. Thus, gender has been viewed to 'equip' women and men differently, influencing the specific ways in which communication is undertaken (Tappen 1994).

Reed and Macmillan (1995) argue that gender has an influence over how friendships in care are established suggesting that men are more likely to build friendships according to shared activities whilst women are more likely to base their associations upon self-disclosure and emotional intensity. According to this gendered model of association, the authors suggest that the low levels of activity in care may be considered to compromise to a greater extent the opportunities available to men in making and maintaining friendships.

#### Identity and interaction: A case study of friendships in care

To date, there have been few situated accounts of gossip that have paid attention to the circumstances in which gossip takes place and their influence upon both when and how participants engage in gossip as an activity. This next analysis will explore the relations of a group of friends residing in one of the care homes visited for the CPCEC project. The



interactions serve as a unique example of gossip in care, highlighting the interactive resources that serve to support identity and maintain friendships.

#### Perspectives on gossip:

Within existing research, gossip has received attention both as a communicative activity and in terms of the characteristics of those who engage in it. Gender has proved a central focus of many existing investigations given the popular association of gossip with femininity and assumptions that it is women who both 'do' gossip and 'are' gossips.

A number of existing studies have defined gossip as the, often critical, exchange of information on an individual who is not present (Leaper and Holliday 1995, Suls 1977, Percival 2000, Cameron 1999). However, Noon and Delbridge (1993) have argued that individuals may be physically present but interactionally absent. Similarly, Blum-Kulka (2000), argues that gossip may refer to individuals who are present but excluded from such exchanges:

"Standard categories of persons who are sometimes treated in their presence as non-persons – as if they were not there – include the very young, the very old and the sick." (page 230, 2000)

#### Gossip and gender:

It has been argued that gossip represents an example of women's 'oral culture' (Jones 1980), serving as a form of 'symbolic capital' (Coates 2000). It has been suggested that a popular conception of gossip as a negative, threatening and divisive form of social interaction undermines female solidarity (Tebbutt 1995). Similarly, Coupland (2000) has argued that "the deprecation of small talk and the deprecation of women have been mutually reinforcing social processes" (page 7, 2000). Rysman (1977) notes that the term 'gossip' is applied inconsistently, with women's communication far more likely than men's to be labelled as such, while Ben-Ze'ev (1994) has suggested that dominant forms of masculinity may also serve to influence men's disassociation from gossip.



Despite such popular associations, Leaper and Holliday (1995) have argued that "there is no clear empirical basis for the claim that women gossip more than men" (page 237, 1995). In a study of interactions between a group of young men, Cameron (1999) found that gossip was a prominent feature of their interaction, and suggested it provided a vehicle for a 'sustained performance of masculinity' (page 269, 1999).

#### Situated gossip:

Few studies have addressed gossip according to its social and cultural context. In a historical study of gossip in working class East End communities (1880-1960), Tebbutt (1995) highlights the gender segregation that characterised the lives of women in working class communities. Through gossip, older women "acquired an important voice in the maintenance of social and moral sanctions" (page 36, 1995). Gossip therefore represented a valuable asset to such materially impoverished women in terms of its exchange value, signalling an interaction of class and gender.

"The verbal grapevine extended the mental parameters of the area which people felt they knew". (Page 178, 1995)

#### The place:

The second care home visited during fieldwork for the CPCEC project was registered solely for residential care and housed fifty-one residents of whom only four were men. The ground floor contained a separate dining room and a smaller 'quiet room', where the majority of the men living in the home were observed to spend their time. Thus, spatial divisions upheld gender segregation within the home. There was a larger day room, seating between thirty to thirty-five residents and in both day rooms the seats were arranged side by side, around the walls, facing inwards.

#### The space:



The foyer area of the home contained seating for four or five people. The seating in the foyer area comprised a two-seater sofa (the only one on the ground floor), and two or three armchairs. These were arranged in a semi-circle with the sofa in the middle, affording their occupants a full view of one another. To the left of the seating was the main front door. To the other side of the seating were the lifts that provided access to the other floors of the home that contained residents' bedrooms. A small booth next to the lifts housed a public telephone.

The group:

The group of friends who made use of this space consisted of five women: Muriel, who participated in the CPCEC project, was known to the research team to have a formal diagnosis of dementia. All but one of Muriel's friends were observed as able to mobilise without assistance: Jan, who used a walking stick, Pam who made use of a Zimmer frame and Edith who also used a walking stick. Amelia, who used a wheelchair following a recent stroke, relied upon care staff to wheel her to the foyer to join the group of friends. She remained in her chair throughout the day. Throughout the period of filming (four and a half days), this group spent the majority of their day in the foyer area, other than at mealtimes, when participating in organised activities or attending an outing away from the home.

The strategic occupation of space:

Analysis of video data for the CPCEC project revealed a number of common characteristics of the communicative experiences of project participants. Overall, levels of communication were low, and of this contact, the large majority was focused upon care tasks. Few occasions were observed when care staff engaged residents in socially-oriented communication with consequently limited opportunities for residents to speak about themselves.



However, as demonstrated by the group of women who spent their time in the foyer of this particular home, there was some variation in residents' experience of the care setting. One key influence upon this variety of experiences being the strategic use of space. The seating in the foyer placed this particular group in an area of high levels of 'traffic' as people entered and left the home, made their way to and from their rooms via the lifts and passed to and from the staff offices. For this reason levels of interaction for the group were observed as far higher than for other residents within the home. A second project participant, residing in the same home and who spent the daytime period in the main day room served as a comparator in this respect.

The group's interactions with others contained greater levels of socially-oriented conversation and provided them with an opportunity to gather information from visitors as they passed through the foyer area. The foyer positioning of the group also provided the means by which to map movements throughout the home, given their view of the lifts that transported people to their rooms and to the communal areas. The range of people with whom the group was able to interact was also greater. As the staff who passed through the foyer had either finished work or not yet commenced their shifts, the nature of their interactions with this group also differed from that observed when engaged in the completion of care tasks. Suggesting that the use of care-speak is specifically tied to the status of 'active' carer.

The group was observed engaged in a number of 'house-keeping' activities, with a shared concern to maintain the tidiness of the foyer area. Members of the group also answered the public telephone when relatives rang to speak to residents and through this gained further knowledge of the contact that individual residents had with family and friends outside the home.

#### Group relations:

Studies placing emphasis upon the relational quality of gossip have argued that the content of gossip is of less importance than its function of supporting relationships (Yerkovich



1977). Thus, Coupland (2000) has argued that as a field of investigation, small talk takes on far greater significance for investigation when read for its relational and social identity functions. At an observed level, relations between this core group of five women were expressed and supported at a number of levels.

**Spatial:** Central to the cluster of seating in the foyer area was the sofa that was placed against the wall. The position of the sofa offered the widest vista of the surrounding area with a view of the front door and through adjacent windows, of the car park outside. From the sofa, the lifts were also in view as were the archways to each corridor, one of which led to the communal areas of the home the other to the staff offices. Amelia and Edith sat at right angles to the sofa with their backs to the corridors behind them. Muriel, who sat to the other side of the sofa, had her back to the front door and was also in the way of the draught caused each time the door was opened. Throughout the period of filming each member of the group returned consistently to the same seat. Jan and Pam, who sat on the sofa were located in the middle of the group and were therefore positioned to interact most easily with the entire group.

**Non-verbal:** Another significant feature of the two-seated sofa was the type (and quality) of interactions that it was observed to facilitate. Argyle (1988) has highlighted a range of non-verbal aspects of communication that are employed to signal affiliation and liking. These include higher levels of touch, closer proximity and mutual gaze. The sofa offered far greater opportunity to communicate using these 'tie-signs'. Levels of touch between Jan and Pam were therefore greater than for the other members of the group, highlighting the influence of the physical environment upon interpersonal relations.

The group was observed engaging in mutual tending. This included straightening one another's clothes and hair, putting away and bringing out one another's walking sticks and frames and minding handbags during short periods of absence. For Amelia, whose hemiplegia caused by a stroke restricted her movement, group members would assist in putting on and taking off her cardigan, tying the bow on her blouse and fetching cups of water.



Verbal: Observable patterns of communication emerged from the analysis of the video data generated for the group of friends. Each member of the group did not engage equally with one another in terms of frequency and duration of direct communication. Jan was the only member of the group who consistently engaged all members in conversation, she also initiated the most conversations. In contrast, Amelia and Muriel were observed to initiate the fewest interactions and contribute the least to conversations.

Jan's status in the group was spatially expressed through her positioning on the sofa as this placed her at the centre of group interactions and at the same time offered her the widest vista of events unfolding throughout the foyer area. Additionally, Jan was observed to offer the most instruction to other members of the group including the ordering of their seating patterns. In contrast, Muriel offered no instructions to any other group members throughout the period of filming. Non-group members also observed Jan's status within the group. For example, when seeking to introduce a new resident, a member of staff approached Jan to ask if the resident could join the group.

#### The management of impairment:

At an observed level, a variety of impairments influenced the flow of conversation within the group and with passers-by. Both Pam and Edith showed indications of impaired hearing and thereby sometimes missed what was said by other members of the group or by those stopping to engage the group in conversation. Jan and Muriel therefore either repeated more loudly comments made or mouthed words to facilitate lip-reading. Amelia was observed making efforts to form words and used gestures and signs to communicate. On a variety of occasions, when passers-by failed to understand Amelia, Jan would intervene to 'translate' what she said or to interpret her gesturing. Muriel's memory loss also generated input from other members of the group, who would remind her of recent events, for example visits from her daughters, and would orientate Muriel telling her the time of day, date and mealtimes. On occasions when Muriel expressed a low mood or distress the group would collectively counter her statements with supportive and positive



responses. However, as will be discussed below, these expressions of low mood also garnered disapproval from the group.

At an observable level, the collective management of impairment had a number of significant outcomes for each member. The communicative 'work' of the group offered the opportunity to undertake a caring and supportive role. The input of other members of the group maintained social engagement for those experiencing difficulties in communicating. As such, the group facilitated a social 'presence' for its members, supporting the communication of needs, thoughts and feelings. The flow of information both within the group and with the wider care home network was also accomplished through this shared communicative work. Overall, the management of impairment by the group demonstrated the value of friendships and group association within a residential care setting. Membership of a supportive network clearly functioned as a buffer to the potentially isolating impact of cognitive and communicative impairment. Thus, according to social situation and circumstances, impairment may be understood as made more or less salient within communication according to the input of all conversation participants.

#### Values:

Gluckman (1963) has highlighted certain key and largely positive functions of gossip including the manner in which it maintains group unity, morals and values and serves to uphold a group's identity. The group was observed achieving consensus on a variety of issues during filming and from this emerged (at least) two overlapping 'meta-values' upheld during interactions.

#### Collectivism:

Levin and Kimmel (1977) have argued that gossip is "most pronounced in small communities where activities of most people are highly visible and easily inspected by one another" (page 169, 1977). The etiquette of group living was an issue to which the group's conversation returned on a frequent basis. Politeness and consideration for others was a



key concern. Occasions when passers-by arrived without greeting the group or departed without a farewell were often commented upon disapprovingly. Knowing when and with whom it was appropriate to discuss events or individuals within the home was another issue discussed by the group. Rules applied to self-disclosure and most especially troubles-telling and these were linked to a shared valorisation of stoicism. This was demonstrated in response to Muriel's expressions of low mood and despair. In discussing Muriel's conduct the group highlight the impact upon the wider body of residents in the home.

Jan - We don't want to sit here and hear all that. She wanted to kill herself this morning, so I told her off, I'm fed up with it.

Pam - It's all wrong how she sits here and makes everybody miserable. The way she is you'd think she was the only one to have trouble. We've all had losses in our life

Through conversation, the group maintained an awareness that many members of the wider collective endured a variety of health problems and disabilities and that many were widowed or had undergone other traumatic experiences in their lives. Therefore, not burdening others with one's problems was indicated as being an important aspect of group etiquette. Not being seen to complain was also an important feature of the maintenance of a public reputation within the home.

#### Respectability:

Linked to the concern to maintain a positive public reputation within the home was the notion of respectability that emerged from interactions within the group. Two key indicators of respectability, as discussed by the group, were conduct and self-presentation. A number of existing studies have placed emphasis upon the opportunity that gossip offers for social comparison and of how the identification of out-group members serves as "the markers against which 'normal' behaviour (is) judged" (Tebbutt, 1995, page 4). Thus commenting upon others' 'unacceptable' conduct was a means by which to uphold notions of respectability within the group.



Distancing themselves from or expressing disapproval of the socially transgressive behaviour of other residents, including rudeness to care workers, excessive noisiness, poor table manners and abusiveness therefore provided the ground rules for respectable conduct for the group. The group was frequently observed to comment upon the appearance of both residents and staff in an evaluative manner. To be untidy in appearance, to wear poor quality clothing or to be seen in public areas without one's teeth were all indicated as being outward signs of a lack of respectability.

Invitees and interlopers:

Existing studies have highlighted the manner in which gossip is organised by principles of inclusion and exclusion (de Sousa 1994) with associated outcomes of both enhancing relational ties within a group (Ben-Ze'ev 1994) and constructing absent others as members of an out-group (Cameron 1999). Thus, separation from the main body of residents not only afforded the group (relative) privacy in their interactions, but also served as a means of maintaining the group's exclusivity. On three occasions during the period of filming the group was approached by a confused resident and waved her away or requested that she return to the day room.

At both verbal and non-verbal levels the group resisted the presence of interlopers. On one occasion a member of staff approached Jan and asked if a new resident could join them. The group fell silent and exchanged eye contact without making a verbal refusal. After the carer led the new resident to another part of the home the group discussed the attempted introduction.

Jan - How can I talk to her, I don't know what to talk to her about, I don't know her.

Edith - Who was that with her?

Jan - That was her husband, how can I talk to her, what can I say? 'nice day innit?'  
- oooh

As noted in a previous study by Reed and Payton (1996), constructing familiarity through a common experience or origin was found to be an important means by which to establish



friendships and associations within care. The study found that individuals who approached others without a common tie were judged as imposing themselves upon groups or individuals within the home.

On another occasion a resident joined the group without being invited and seated herself on the sofa. The group used silence to signal their sense of intrusion. Whilst sat with the group, the 'interloper' made repeated conversational openers, which received no response from the group members. Initially, the group maintained a silence for five minutes without making eye contact with the interloper. They then engaged one another in brief exchanges without including the new arrival. The subsequent conversation highlighted the sense of trespass.

Edith - She knows that you sit there and I told her

Jan - She knows we don't talk to her

Edith - She has to have her own way

Models of social exchange applied to gossip have highlighted the social value and worth of information that is exchanged during episodes of gossip (Rosnow 1977). Collins (1994) notes that "to be an active gossip one must have an independent contribution to make to the talk" (page 106, 1994). Attempts to join the group were therefore by no means always resisted, on a number of occasions other residents were invited to participate in the group's interactions and the management of these invitations provided an indication of the grounds for temporarily joining the group. On one occasion a resident approached the group, announcing, "I must tell you this", thereby signalling her status as an 'active gossip'.

Prompts and resources:

A number of material prompts served as conversational triggers for the group. On one occasion a maintenance worker for the care home brought in photographs of his garden. As the group circulated the pictures, the conversation turned to descriptions of gardens and gardening stories. On another occasion Pam produced a packet of California raisins from her handbag and shared them with the group. This prompted a story from Pam of a



visit to family in California. Following on from this Pam, Jan and Edith discussed visits to family in various parts of the world. These shared experiences of dispersed families established a commonality between the members of the group.

As previously noted, appearance and self-presentation were a key concern for the group. In addition to evaluating the clothes and looks of staff and other residents, the group paid on-going attention to one another's appearance at both verbal and non-verbal levels. Supporting the findings of existing studies (Holmes, 1988, 1993) appearance- related compliments were often paid as the openings to conversations between the group.

Muriel arrives in the foyer. Pam, Amelia and Edith are already seated:

Muriel - You look very nice all of you ladies

Edith - You, look at you, you look very nice

Muriel - Well I try to, I try to

Edith - I've just been to change my jumper, I'd dropped tea down it.

The evaluative attention paid to the appearance of other (female) individual's in the home, the payment of appearance-oriented compliments at a verbal level and the mutual tending to one another's clothing and hair at a non-verbal level, underscores the significance of self-presentation as a salient resource for the group.

Day-to-day events within the home, such as mealtimes, were also a source of conversation between the group, as were one-off events. A visit from a mobile clothes shop prompted an extended discussion within the group and offered a pertinent example of a salient resource, providing opportunities for an expression of self and the maintenance of a social identity. It is also relevant to recall that a large proportion of the East End Jewish community were involved in the tailoring and dress-making industry and as such the arrival of a clothes shop may be understood to have both a gendered and cultural resonance for the group of friends. (See Appendix 10 for full transcript).



The interactions within the group following the visit from the shop illustrated the manner in which new information or experiences were absorbed and made sense of through an establishment of group consensus. Despite the group's disapproval regarding the quality of the clothes, the visit from the shop rippled outwards at a conversational level, filling the afternoon. In passing judgement on the clothes the group used the event as an occasion to express individual taste and to demonstrate their unity through shared standards of dress. At a non-verbal level a number of features of the conversation offer an insight into group relations.

Throughout the talk, each member of the group employed a variety of back-channel signals, including nods, expressions of agreement and face pulling. Despite lulls in the conversation, while talking, the group members frequently overlapped their comments with the endings of others or followed on immediately from the remarks of the previous speaker. Argyle (1988) suggests this conversational 'synchrony' serves as another indicator of affiliation. In contrast to the more lengthy speaking time of group members when engaged in self-disclosure, the brief turns taken by the group during this exchange meant that the conversational 'floor' was shared more evenly between them.

#### Reputation:

As the interactions of the group of friends suggest, a resident subculture influences the reputation of individual residents in care settings. According to group notions of respectability and shared values, fellow residents were identified as out-group members. Highlighting the importance of self-presentation and conduct to wider notions of respectability the group discussed two other residents as 'the screamer' and 'the scruff'.

A number of existing studies have drawn attention to the exchange of information that is characteristic of gossip, arguing that gossip demonstrates an interest in the reputation of others (Percival 2000), evaluation of them (Leaper and Holliday 1995) and as providing a basis for social comparison (Suls 1977). During the period of filming the group were observed collaboratively mapping the conduct of individual residents. Muriel's reputation



within the group provided an illustrative example of this. During a conversation with the researcher about the CPCEC project, Jan, Pam and an invitee offered an unprompted account of Muriel's conduct. (See Appendix 11 for a full transcript)

In building a reputation for Muriel, the group collected instances of her conduct and these observations served as the interpretative resources by which they constructed an account of her 'condition'. In their conversation with the researcher, the group made use of the sum of these observations in order to validate their perspective to a third party. This reputation-building process provides an insight into how social relations between residents are managed and structured. It also underscores the importance of attention to resident relations in gaining an understanding of experiences of care.

Temporal vista:

As noted by Diamond (1990), the biographies of individual residents have little influence upon the ways in which they are known in care, despite the wealth of experience upon which an older person is able to draw and the relevance of this history to their social identity. In contrast, the conversations of the group demonstrated the importance of being able to make reference to prior 'selves' and experiences over time in supporting a notion of self in the present. In traversing their biographies at a conversational level, the group members offered insights into their own (gendered) histories and experiences of 'gender mobility', for example travelling along a biographical trajectory as daughters, mothers and grandmothers. Conversations for the group therefore incorporated a temporal range, the ability to reach out in time providing an important conversational resource. Making reference to these personal histories was also a means of self-disclosure for group members.

For example, as the group sat discussing their experiences of swimming, Jan offered an account of the swimming abilities of her family and traced the intergenerational influence upon family members regarding their relationship to swimming (see Appendix 12 for a full transcript). The account demonstrated Jan's personal temporal vista and was notable



for covering four generations of her family. In so doing she signalled her own relationships as a daughter, sister, mother and grandmother.

In addition to the inclusion of their own life histories in conversation, the group plotted through time, the progress and changes of different residents within the home. Plotting paid attention to the downturns and upturns in the health and well-being of residents and a range of sources were drawn upon in so doing. This included references to appearance and changes in appearance over time, information gathered from reports by fellow residents and visiting family and knowledge of the health of individual residents informed by occasions when they stayed in their room or received a visit from the doctor. The group also drew upon perceived changes in the character or behaviour of a resident and, as noted above, this provided a basis upon which the group would build a reputation for individual residents.

Muriel (to Jan) - Lovely cardigan that is (Jan smiles). I've just seen (name of resident), oh terrible

Jan - Wreck of a woman isn't she

Muriel - Well, I couldn't understand at first but thought well that must be her, I think it's terrible

Jan - shocking she looks

Muriel - Oh, it's not her at all, terrible, she was such a nice looking lady wasn't she? Did you recognise her at first? I didn't.

Jan - I saw her on the landing, she didn't even have any teeth in and that made it worse

### Mapping:

As an accompaniment to plotting trajectories through time, the group engaged in the social mapping of other residents, achieved through locating them within a network of relationships. These social maps developed in detail and complexity as new information was incorporated over time. Again, the group's location in the foyer area of the home played a key role in this practice as they were able to gather information from a variety of visitors in order to paint a picture of residents' family networks and beyond this to the connections between the differing networks. Given the common geographical origins of



many of the residents within the home, and shared social experiences, such as worshipping at the same synagogues, the group were enabled to chart a variety of social connections and ties that existed between the familial networks associated with the resident body. (See Appendices 13 and 14 for examples).

A vista across time and place therefore afforded important conversational resources for the group. Despite their own relatively static experience of life within the care home, at a conversational level, the group demonstrated an ability to 'travel' through time and between places, facilitated by their shared wealth of experience and knowledge of the London Jewish community. Importantly, while a variety of sensory, cognitive and communicative impairments compromised the ability of individual group members to either gather or retain this complex social information, their membership of a group served to maintain their participation.

Friendships in care: Conclusion:

De Sousa (1994) has argued that gossip may be understood as a 'subversive form of power' that operates outside of more socially sanctioned channels of communication and sources of knowledge to which access is restricted. The interactions of this group of friends show how influence and status within care home settings are achieved in gendered ways. Bereft of material resources and restricted in movement, the gathering and exchange of gossip demonstrates the importance of 'symbolic capital' to residents of care settings.

An exploration of conversations 'in action' has provided a basis upon which to develop an account of situated gossip. Gossip was observed to provide a vehicle for maintaining group association marked by on-going expressions of affiliation at verbal and non-verbal levels. The use of gossip to maintain friendships in care therefore supports existing perspectives on gossip as a form of 'small-talk' notable for its relational and social identity functions (Coupland 2000). At the same time, the importance of the content of gossip has been highlighted as an interaction-level resource for social exchange and as a basis upon which non-group members established their status as invitees.



Previous studies of gossip have largely focussed upon the spoken aspects of this style of communication. A particular benefit of the data generated for the CPCEC study was the opportunity afforded to pay attention to accompanying non-verbal aspects of gossip. In addition to the non-verbal back channelling throughout the conversation, the group were observed engaged in mutual tending. The care and attention paid to one another's appearance and well-being may be understood as supporting the verbal exchanges and consolidating group relations. The group was also observed making a strategic use of silence on a number of occasions and this proved an important aspect of communicating resistance to interlopers.

Gluckman's (1963) functional analysis of gossip as a means by which group values are established and upheld has been echoed in the present study through an attention to the politics and practices of inclusion and exclusion that informed group interactions. Of particular note is the manner in which gossip served to maintain a distinct resident subculture, within which residents were enabled to express and explore social identities and experiences, often precluded by the nature of contact between care workers and residents.

The interaction of time, place and space with social relations has also been highlighted. The strategic occupation of space by the group played a key role in the level and quality of interactions in which they engaged while serving as an expression of group relations. As a conversational resource the practice of navigating temporal, spatial and social maps was a feature of this particular instance of situated gossip that has been given limited attention in existing studies. Despite the marked constraints upon mobility and social engagement occasioned by entry to care the group of friends demonstrated an ability to extend the boundaries of their experience at an interactional level. At the same time the group proved itself adept in making use of the limited resources available within the care home setting as a variety of conversational prompts and triggers provided the basis upon which to express both a group identity and maintain notions of self within this group.



The absence, from the present study, of comparable data generated from conversations between men precludes consideration of the extent to which this style of communication may be viewed as gendered. However, it is worth noting that men were largely absent from participation in the interactions of the group and were rarely the subject of conversation, thereby echoing Tebbutt's (1995) finding that men are 'bystanders' to the largely feminine network that gossip supports. The overall absence of men from this care setting and the gender segregation observed within the home may account for this interactional absence.



### **Identity in Place: Part Three**

A particular focus of the present study has been an exploration of the interactive quality of identity. It has been shown that identity is open to negotiation, co-constructed within the context of particular social environments and according to a variety of social practices. Thus care may be understood as a dynamic that shapes identities.

In a study of familial caring relationships Hanson (1994a) argues that dementia mediates the negotiation of power within relationships. The present study reveals such a process is also identifiable within formal dementia care. A medicalised discourse on dementia provides the 'interpretative resources' (Wetherell 2001) by which sense is made of an individual's identity and conduct. It has been shown that this process is upheld interactively, materially and spatially through practices of regulation, surveillance and control that are institutionally authorised.

A feature of the situated construction of identity is the manner in which the dynamics of care produce ways of knowing and categorising individuals. As previously argued in relation to the referencing of gendered labels, the way in which people are treated and their status within care is structured according to a public reputation that is shaped by certain salient aspects of their identities. A key feature of this process is the manner in which a resident's reputation is selectively constructed, largely according to the perspective of care workers. Those aspects of an individual's identity or conduct that were of most relevance to their contact with care workers and the completion of care tasks were found to be most likely to contribute to their public identity. At the same time, this process may be understood as framed by a wider culture of dementia care.

#### **The construction of sexuality in care**

Introduction:



When thinking of sexuality it is useful to recall its many dimensions. As part of an inner world of thoughts and feelings, sexuality fuels wants and desires. It holds a meaning that is intimate and personal. As an aspect of identity, sexuality imbues self-image and social relations and is a key feature of biography and life experience. At a structural level it serves as an axis upon which power relations are organised in society. Sexuality also exists discursively; it is defined and ascribed meaning at a shared, social level through discourse. Discourses on sexuality provide categories and labels that order and give value to feelings, expression and identity. Notions of morality, respectability and taboo inform this process. Such discourses may usefully be understood as organised and organising systems of representation.

The following analysis focuses upon the representation and accounts of sexuality in a dementia care setting. It is argued that treating proxy (second-hand) accounts as transparent representations of the conduct and expression of people with dementia is problematic. Instead, it is suggested that these accounts are interpretations, mediated by the perspectives and interests of those who offer them.

"If we treat descriptions as constructions and constructive, we can ask how they are put together, what materials are used, what sorts of things are produced by them" (Potter, 1996, page 98).

### Sexuality and ageing:

Limited attention has been given to sexuality and ageing and in particular that of older people residing in institutionalised forms of care. That older people are often perceived as 'sexless', or 'de-sexed', is linked to wider discourses on age and decline but is often compounded by a focus upon ageing and its effects in the organisation and provision of services to older people. Within health and social care, the processes of assessment and categorisation of older people rarely connect sexuality and ageing, other than when sexual expression or conduct is deemed in some way aberrant. This inattention to sexuality is a key feature of ageism (Ford 1998). Neither in policy nor practice does the older lesbian or gay man exist as a category of client. This being despite growing recognition in social



gerontology of the particular issues that arise for non-heterosexuals as they age (Lee 2002, Heaphy et al 2003).

A characteristic of existing research into the lives of older people is that age provides a framework for an understanding of sexuality. Key concerns being to highlight differences as compared with the wider (younger) population and problems associated with maintaining sexual activity in old age (Meston 1997, Duffy 1998, Kessel 2001). How sexuality may interact with an embodied identity that alters over time is less often addressed. Additionally there is a need to develop an understanding of gendered differences in the experiences of ageing and embodiment and their relevance to sexuality (Fleming 1999, Tunaley et al 1999). To date, limited consideration has been given to the manner in which sexuality and sexual activity may form part of the wider maintenance of a gendered identity (Jackson and Scott 1996, Richardson 1996).

#### Gendered sexualities:

With some exceptions (Campbell and Huff 1995, Loehr et al 1997, Archibald and Baikie 1998) the interaction of gender, ageing and sexuality remains largely unexplored. What it means to be sexually active in a society where youth is associated with beauty and, for women especially, where sexuality is often tied to reproduction are key issues when considering attitudes to sexuality and ageing. Throughout the life-span differing social rules govern the expression of sexuality for men and women. How such gendered mores may continue to apply in later life is little understood (White 1982, Fleming 1999). Increasingly, the rules of sexual conduct appear open to negotiation and contested, as embodied within advertising and the media by such figures as the new 'ladette'. However, despite the politicisation of sexual relations and the evolution of new or alternative sexual identities within youth culture, such reinvention rarely extends to or acknowledges older people (Archibald and Baikie 1998).

#### Ageing and the gay community:



Recent research among older non-heterosexuals has argued that their experiences are poorly accounted for in contemporary policy and political discourses on 'social exclusion' (Heaphy et al 2003). It has also been argued that the 'heteronormativity' of care services compounds the invisibility of older lesbians and gay men (Harrison, 2001). In a review of existing research, Pugh (2002) places emphasis upon the diversity that is a characteristic of the older gay and lesbian population and warns of the problems associated with making generalised assumptions regarding the needs and experiences of this group.

#### The challenge of sexuality and dementia: The research question

Despite reforms to care practice in the UK, proposed under the Care Standards Act (2000), there remains a silence regarding sexuality in policy and legislation pertaining to care for older people. This corresponds with the limited consideration given to this aspect of identity across health and social care provision. In a review of the practice treatment literature on dementia and sexual activity, Harris and Wier (1998) point out that assessments by professionals rarely include attention to sexual functioning or seek to elicit information from a partner regarding the sexual dimension of a relationship. This despite findings that indicate the continuation of sexual activity in later life is beneficial to health (Weeks 2002).

Within marital relationships, the onset of dementia has been found to prefigure a decline in levels of affection and sexual activity, when compared to a control group (Wright 1998). Attention has been paid to the difficulties of negotiating such changes from the perspective of the partner/carer, including the impact upon carer burden of a loss of intimacy (Morris et al 1988, Lewis 1998, Baikie 2002). Little is known of the perspectives or experiences of people with dementia with regard to the effects of the condition upon their sexuality.

Within discourses on care, sexuality is constructed as a problem when associated with dementia and cognitive impairment. Furthermore, sexuality is often understood as, and reduced to, acts of sexual expression - the observable and encountered manifestations of



sexual activity and desire. Particular attention has been paid to the challenges for care staff in managing and regulating sexual expression and the range of strategies that may be employed to intervene when sexual expression is deemed problematic (Wallace 1992, Ehrenfeld et al 1997, Barnes 2001). As such, there is a specific concern with sexual expression as and when it is deemed transgressive of the norms of conduct upheld within care settings. That it may hold relevance to dementia care at a wider level, shaping experiences of care and with a potentially important bearing upon the provision of person-centred care, remains largely unexplored.

#### Dementia, sexuality and residential care:

With regard to older people residing in care there is an overall absence of attention to sexuality and few opportunities for its expression (Aizenberg et al 2002). However, if a person has dementia then this heightens the levels of surveillance and regulation they are subject to within care home settings. The increasing attention given to sexuality in dementia research also signals the anxieties associated with the sexual expression of people with dementia. Rarely, is such expression viewed as positive or beneficial to an individual. Rather, it is discussed largely in terms of the disruption caused to the dynamics of care settings. Archibald (1998) found that sexual expression targeted at care workers, sexual exploitation or coercion and public sexual expression reportedly gave particular cause for concern, alongside any form of sexual expression that appeared to deviate from the (heterosexual) 'norm'. Thereby highlighting the manner in which the more disruptive forms of sexual expression appear to generate greater levels of anxiety.

A study of cognitively intact older men in care (Ballard-Poe et al 1994) found that despite intimacy being ignored within measures of quality of life for this group, all interviewees reported valuing intimacy, especially of a social and non-sexual physical nature. However, intimacy and touch is frequently problematised within care, arguably especially so in relation to men, suggesting the importance of distinguishing the expression of affection and a desire for intimacy from those occasions when there is a clear sexual intent. In a review of existing studies, White (1982) has highlighted that older men's sexuality has



been the subject of far more investigations than women's, despite the predominance of women in upper age groups.

#### Sexual expression and its response - the significance of gender:

Certain findings have been replicated across the limited number of non-medicalised studies of sexuality and dementia. Of particular note is the importance of gender to the perception and response to sexual expression by people with dementia. Men have been reported to engage in a wider range of sexualised activity and to express themselves sexually more frequently than women (Archibald 1998, Ehrenfeld et al 1999). Sexual expression by men is more often noted by care staff (Archibald 1998, Ehrenfeld et al 1999) and their conduct is more likely to be perceived as carrying a sexual intent (Mayers & Solberg 1994). Sexualised conduct by men is also more likely to be pathologised, triggering referral to a medical professional (Archibald 1998) and is more likely to provoke a negative response from staff (Ehrenfeld et al 1999). Harris and Wier (1998) noted that removal to another wing of a home was a common response to sexual behaviour deemed inappropriate.

In contrast, the sexuality of female residents is often overlooked and passes unmarked by care staff (Nay 1992). Existing studies have noted that the sexual activity of women with dementia and cognitive impairment prompts a protective response from their families and care workers (Wallace 1992, Archibald 1998, 2003, Ehrenfeld et al 1999). As such women are rarely considered to possess an 'active' sexuality, rather their sexuality is a cause of concern mainly in respect to the masculine attention that it attracts. Despite recognition, within existing research, of the significance of gender to issues of sexuality there has been little discussion of why gender mediates responses to sexual expression or of the outcomes of this for care practice. Emerging from this overview of existing findings is an indication that sexuality, and more specifically sexual expression in dementia care, is ascribed meaning according to a gendered dichotomy. Masculine sexual transgression contrasts with feminine vulnerability often generating a punish/protect response within care settings.



## Gender relations in residential care:

Existing studies (Mayers 1994, Archibald 1998, 2002, Ehrenfeld et al 1999) report that male residents initiate the majority of sexually based interactions with both staff and residents. This may be read as a demonstration of predatory masculine sexual conduct or as an outcome of there being a higher level of cross-sex encounters for men in care (or, perhaps both). It is important to consider how a predominance of women, both as care providers and recipients, may affect conduct and responses to that conduct. Throughout the period of fieldwork it was noted that cross-sex interactions dominate in men's experiences of care, illustrating that the care home is a setting experienced differently, according to gender. One can speculate - if women were in receipt of care provided mainly by male carers and interacted more often with male rather than female residents, would their sexual expression be different? And would it be more often marked if the workforce were predominantly male?

The demographics of dementia care are therefore an important consideration when addressing sexuality and sexual expression. When drawing upon proxy accounts of the conduct and experiences of people with dementia there is a need to recognise how such accounts are mediated by social difference. An act of sexual expression holds meaning according to the perspective from which it is judged. Added to this is the influence upon data of the perspectives and evaluations of researchers and investigators who collate and present findings according to specific concerns and research conventions. It is clear therefore, there is a need to disentangle the various perspectives and interests embedded within accounts of sexuality.

## Care-based perspectives on dementia and sexual expression

### Observation and video data:



In a recent ethnographic study of the social interactions between older people in institutional care, Hubbard et al (2003) note that within the literature on sexuality and residential care, there has been little exploration of the ways in which residents express their sexual selves. The authors highlight a number of examples of the everyday sexual expression of residents, which are characterised as 'flirtation and affection' (page 106, 2003). During the period of fieldwork for the present study examples of conduct were observed and filmed that similarly demonstrated warmth, closeness and intimacy between residents.

There were a number of occasions when conversations served as an opportunity for an expression of sexuality. For example, during an episode of care a female resident was observed engaging in a humorous fashion with a male care worker, offering her hand in marriage and suggesting that they began 'courting'. In another home a male resident approached a female project participant, paid her a compliment on her appearance and asked permission to kiss her cheek. As they parted, he took her hand and kissed it and she smiled in return.

Despite restrictions to their privacy, some residents engaged in moments of clear intimacy with one another. In one unit, a male and female resident were observed as they sat together at a table; each placed a hand upon the others upper leg, tilted their head towards one another and spoke in softened tones. They remained together for a period of over twenty minutes until they were asked to move by care workers who wished to lay the table for dinner.

Intimacy, affection and flirtation are positive and meaningful aspects of communication that may support and cement relationships with and between people with dementia. They may also provide an opportunity for sexual expression and sexual intimacy, the potential benefits of which are often overlooked. As such, there is a clear requirement to move beyond a focus upon sexual expression as a problem within care, to consider strategies that may facilitate and enhance this aspect of the lives of people with dementia residing in care.



## Documentation:

As previously noted, analysis of files and care plans revealed that sexuality was made reference to only when deemed problematic. There was an overall absence of positive references to sexuality in documentation. None of the files or care plans to which the research team had access contained any form of assessment that directly addressed the sexual needs of individual clients, despite the potential benefits to person centred care of this aspect of care planning (Wallace 2003).

Sexualised conduct was often represented as symptomatic of dementia. There appeared to be a particular concern with behaviour deemed inappropriate and often labelled as 'disinhibition'. Also, where cognitive impairment was considered to render individual female residents vulnerable to approaches by male residents.

'(Date) - request for psychiatric assessment. Reason: May be at risk from other residents, very biddable. Staff witnessed Mr X being 'intimate' with (name). Mr X moved to (another) wing of home'. (Care file for female resident)

While existing studies have proffered various strategies that may be employed to manage perceived problems associated with sexual expression and sexual relations within care, there remains little exploration of the outcomes of such interventions for the residents concerned. For example, little is known of the impact for residents of removal to another wing or discharge from a home (Kuhn 2002), thereby raising the question of whose interests such interventions are designed to support.

## Carers' perspectives:

In common with the growing number of existing investigations of sexuality and dementia, the accounts and perspectives of a largely female sample of care workers inform this study. A feminised standpoint therefore filters our understanding of sexuality in care and is further shaped by the age gap between care providers and recipients. Sexuality is tied to



identity and is made sense of through it, suggesting the need to recognise the gender and intergenerational 'effect' upon care-based perceptions of sexuality and the data generated from accounts by workers. An interaction of identity, conduct and third party evaluation therefore provides a model by which the construction of sexuality in care settings may be understood.

"I remember doing a course, and they showed a picture of an old man and an old woman kissing and everyone went 'errr', because it's the fear of 'oh God, you know that could be my mum and my mum doesn't kiss' and that sort of thing. And I think a lot of people just dismiss it as not being needed." (rhec16(f))

Care workers interviewed for the project were asked to offer an account of the ways in which residents expressed themselves sexually and how, if at all, they responded to this. One care worker asked to 'pass' on questions regarding this aspect of care. Of the 27 responses (from five men and twenty-two women), the majority of respondents cited examples of the type of sexual expression they had observed and gave some indication of the response it elicited.

Of those respondents who offered an indication of the frequency or level of occurrence of sexual expression, six (22% of total respondents) indicated that they had either not noticed such expression or that it did not exist within the care environment in which they worked. A further six (22%) respondents offered examples of sexual expression but indicated a perception that it rarely occurred. This finding may suggest that people with dementia residing in care seldom express their sexual selves. An alternative reading is that these responses indicate that care workers rarely take notice of sexual expression or are not positioned to recognise such expression when it occurs.

Two (7%) carers indicated that sexual expression was a natural and/or expected aspect of the lives and relations of people with dementia residing in care, but did not offer specific examples of the types of expression they had observed. Of those respondents who did cite examples, five (18%) noted occasions where such expression was deemed positive, often highlighting its potential to support biographical continuity. One respondent signalled the



manner in which self-presentation represented a form of sexual expression for (female) residents.

'Some of the women still like to get up and put lipstick on and that sort of thing. That's showing a sign of sexuality, to an extent of still being feminine.' ... "I know for most residents (sexual expression) is not really an issue, apart from someone who still likes to look feminine or have men residents who notice them and I'm sure that makes them feel really great.' (rhec16(f))

Echoing the representations of sexuality in care documentation in the care homes, a further 14 (52%) interviewees signalled a perception that the expression of sexuality by residents was problematic, either with regard to their own relations with residents or to the wider dynamics of the home. This finding seems to indicate that care workers are most likely to take note of sexual expression when it requires their intervention, thereby emphasising problem behaviour and potentially under-reporting the more positive aspects of residents' conduct (McCann et al 1997).

#### Gender and sexual expression:

Of those carers who offered specific examples of situations or encounters they deemed problematic, the majority (n. = 7) spoke of male residents. This included one respondent who offered an example referring to a man and another regarding a woman. Despite the predominance of women in all the care homes involved in the study, few respondents offered examples of sexual expression that specifically referred to women. This echoes the findings of existing studies suggesting that women's sexuality is often overlooked in care settings (Nay 1992). Interestingly, of the five male carers in the sample, three indicated that sexual expression was in some way problematic, two of whom offered specific examples citing female residents.

These findings are open to more than one reading. The proportion of carers citing examples involving male residents may suggest that there is a greater likelihood that men will initiate sexually-based encounters in dementia care settings. It may indicate that care workers are more likely to note sexual expression when it is directed at them. Given that



female carers cited examples involving men, while male carers offered examples relating to women, a gender dynamic is suggested in which the gender of both staff and residents influences perceptions of sexual expression. Further investigation of the experiences and perspectives of male care workers may assist in exploring this dynamic.

Of those staff who offered examples of sexual relations between residents, three respondents echoed the perspectives noted within care home documentation and existing research in which sexual expression was framed according to a dichotomy of masculine transgression and feminine vulnerability and an associated punish/protect response.

'We've not had any real problems with (sexual expression), but you know we've had men up here saying to the ladies 'you can come to my room later' and things like that you know.' (rhcc24(f))

'We have a gentleman here who has absolutely no inhibitions and in fact, was moved here because he was a menace to the female residents at the other home that he was at.' (rhcc21(f))

'You have some men who do that but we are protective of the lady and when she goes in we make sure we lock her door and then at a certain point in the night when the other man is asleep we open it.' (rhlc32(f))

It is pertinent to ask what resources care workers draw upon when making sense of the sexual expression of residents. While a medicalised notion of dementia often prompts a perception of such expression as symptomatic of the condition, it also appears that wider stereotyped notions of masculine and feminine sexuality are invoked to account for relations between residents. A recent case study offered by Archibald (2003) has highlighted the manner in which such stereotypes can lead to the misrepresentation and misinterpretation of residents' conduct with detrimental outcomes for those concerned.

Types of sexual expression:

There was variation within interview responses as to the level of seriousness with which sexual expression was viewed. Carers spoke of residents as 'cheeky' and 'cute' indicating a



somewhat infantilised view of sexuality, echoing the more general use of babytalk in communication observed between staff and residents. There was also variation as to the nature of the sexual expression noted by staff, with some reporting conduct deemed inappropriate whilst others highlighted verbal expression.

"We have one resident who likes pinching bums, that's all." (rhdc28(f))

"There's a man who is a bit sexy, he likes to touch, if you let him touch".  
(rhec10(f))

"We've only got one lady who maybe does that and she's quite forward, like she'll say 'oh, I love you' and 'darling' and all of that, but you can just be friendly with her, but try not to get over-friendly". (rhec13(m))

"The male residents, yeh they talk about the naughty details they talk about 'yeh, when I was younger I played around a lot, I didn't have just one wife or one woman'. But female residents, I think they talk to female staff, yeh they can talk about anything but hardly with male staff, but the male residents they are free to talk". (rhec1(m))

Respondents noted a variety of different forms of sexual expression. The inappropriate use of touch was the most commonly cited form of problematic conduct. Problematic verbal expression included requesting sex or making sexual comments to staff and other residents. More positive examples included the discussion of sexual histories, humorous 'banter' and joking.

Intervention by care workers:

Accounts given by respondents as to when and how they would intervene or seek to regulate sexual expression also varied and were tied to the perceived acceptability of sexual expression. Differing rules applied as to what was considered appropriate within public spaces such as day rooms as compared to the 'backstage' (Lee-Treweek, 1997) areas of the home. Respondents highlighted the various concerns and perspectives that care workers felt compelled to negotiate within dementia care. One consideration was the



potential for complaints from relatives. Carers also noted the importance of paying attention to both the dignity of an individual resident and the responses of other residents.

"I don't think I will discourage because they are old enough to have, to do what they want to do. With me, I will tell them to stop. If residents are willing, we leave them alone, if not then we discourage." (rhec10(f))

"You have to be understanding but you have to also make sure it's not going to offend other people, but in private it's fine but sitting in the lounge doing something like that is not really." (rhlc15(f))

"There is one or two residents, they are like touching other residents all over the body and then if you see anything like that you try to separate them". (rhec19(f))

"We, as professionals, have got difficulties, we don't seem to think it's acceptable and we seem to look at it from the point of view of the daughter or the son is going to complain, but what about the individual who is expressing that desire? People basically feel very uncomfortable because they don't like the complaints basically." (rhkc2(m))

Balancing the perspectives of the individual with that of the wider resident body was a repeatedly cited concern during interviews with care workers, with regard to many aspects of conduct and care. This concern highlights the influence of a resident subculture, through which shared values, and consensus over notions of appropriate conduct, are upheld in each home. Raising the question of how situations are best resolved when an individual's values prove not to be consonant with the wider culture of a care home (Archibald 2003).

Legal/ethical implications:

Another significant concern for care workers was situations in which residents with differing levels of perceived confusion and awareness were involved in sexualised relationships and encounters.

"You would have to appeal to the person who has the ability and make them aware that what they're doing is abusing another person and that there are procedures in



place to deal with an adult abuse situation.' ... 'I think you should make it very, very clear to that person if what they're doing is not acceptable and then, if they persist, then you would have to invoke a procedure.' (rhcc21(f))

Care providers are both legally and ethically accountable for the well-being of service users. For this reason there is an on-going requirement of care workers to balance residents' autonomy with levels of perceived risk, including decisions regarding an individual's capacity to consent to sexual relations. On this point, Haddad and Benbow (1993) have highlighted the dangers of global judgements regarding competency to make informed decisions, arguing instead for on-going and context-specific consultation with people with dementia.

Despite growing attention given to the complex considerations involved in the management and regulation of sexual relations, there has been little debate of the underpinning ethical issues. It therefore seems important to consider what rights care providers have to intervene in the sexual lives of people with dementia and what rights are consequently denied when such interventions occur. Kuhn (2002) has argued that while care workers often assume responsibility for taking health care and financial decisions on behalf of people with dementia, it is open to debate "whether surrogate decision making extends to the personal realm of sexual intimacy" (page 167, 2002).

#### Sexual expression:

Overall, considerable variation existed within responses in relation to the type of sexual expression noted by carers, the meaning attached to it and the corresponding responses and interventions employed. One carer decided to 'pass' when asked to give an account of residents' sexual expression, while another requested the tape recorder be switched off when offering an example of inappropriate conduct, indicating a degree of unease in addressing this topic. That a further six respondents indicated either not recognising such expression or believing it not to be present within their workplace also suggests the presence of stereotyped attitudes regarding sexuality and ageing. From such variation emerges an indication that sexual expression is perceived and addressed according to



individualised beliefs regarding age, dementia and sexuality that carers import into their work, highlighting the difficulties in upholding a clear organisational stance. As one care home manager indicated:

'It affects a person's own feelings, you put your own hang-ups or whatever on sexual relationships within the home. A lot of people feel it's not right, it shouldn't happen and then they get all uptight about it.'

This finding supports existing calls for a need for both training and a clearly stated policy on sexuality and sexual issues in care settings that incorporate an attention to both the interests of residents and the support needs of care workers (Archibald 2001, Kuhn 2002, Canadian Nursing Home 2003). At present it appears all too often the case that judgements upon the appropriateness of conduct and decisions regarding intervention are taken by care workers with limited formal guidance or support.

#### Sexual expression targeting care workers:

A number of respondents cited examples of sexual expression aimed at staff. Indeed, the majority of examples citing problematic sexual expression referred to that which targeted care workers. During interview, ten (37%) respondents reported occasions when residents targeted carers when expressing themselves sexually. This included two respondents who noted occasions when inappropriate sexual expression targeted both staff and residents and one who did not specify the nature of the sexual expression. This finding may be read as supporting the view that care workers are most likely to notice sexual expression when it is targeted at them.

Two male carers cited occasions when female residents expressed themselves sexually during conversation in a manner they deemed inappropriate. Four female care workers noted occasions when residents used touch inappropriately, signalling the vulnerability of care workers when providing care. During such incidents attention shifts to the embodied presence of the care worker in a manner that is both unwelcome and outside of their control. Archibald (2002) has highlighted the perceived threat that such encounters pose to



the sexual 'reputation' of female care workers. With regard to perspectives on sexualised episodes of care, a number of factors reportedly influenced what conduct was deemed unacceptable and the response it elicited. Older carers reported the perception that younger and less experienced female staff found it more difficult to cope with sexual advances from residents. They also identified the need for more support in this area for younger staff, echoing the findings of existing studies that have highlighted the distress that such incidents can cause and their potentially detrimental impact upon carer/caree relations (Barnes 2001, Archibald 2001, 2002).

"You just have to be sort of firm and say 'stop it', you know. But of course, when they're young they don't, people don't know, they don't sort of treat it as matter of factly as when they're older." ... "I think a lot of younger staff might need more training in how to deal with any male resident who takes to them sexually." ...  
"The older person, you don't take it for granted, but we know how to deal with it".  
(rhfc23(f))

The interactive level at which sexualised care was made sense of and the criteria by which it was interpreted were also highlighted:

'I mean for me, I understand all these kinds of things, I just ignore things, as long as (they are) in the limit. If anything else goes below the limit, then that's the time (that it) is no good. But if it's only a smack on the bum, my husband does that, so it doesn't worry me at all.' (rhdc28(f))

'Sometimes they put a hand, they say sorry, but (that) means they know what they are doing. You see the difference when it's innocent, if they say sorry it means it's deliberate, you tell them off.' (rhec9(f))

Such responses demonstrate that the interpretation and labelling of touch as inappropriate is far from standardised across the staff group. They also illustrate the way in which sexualised episodes of care are rationalised by some care workers, particularly with regard to their physical vulnerability while undertaking bodywork (Wolkowitz 2002).

Getting a reputation:



Sexually inappropriate conduct, especially when targeted at care workers may be understood as an important contributor to a resident's reputation within care settings. Throughout the study those aspects of a resident's identity or behaviour that proved most significant to the provision of care were observed to form the over-riding motifs by which they were known and hence treated by staff. In addition to the formal representations of residents via care home documentation, there was some indication of a secondary and less visible level at which residents were known. As noted disapprovingly by one male care home manager, carers discussed residents between themselves, sharing information on them:

'I'm sure you'll hear stories where 'oh I was bathing Fred Smith' for example 'and he got a hard-on while I was bathing him', from a female member of staff, 'it's disgusting, he should have it cut off' or 'oh, you should have put the cold shower on him' and these sorts of things, which I think is appalling.'

The less formal processes by which residents are categorised and made known may be understood to serve a number of functions. Occasions when carers share information regarding residents provide opportunities both to give and receive support, not least in relation to difficult or challenging experiences. When care workers discuss their experiences of sexualised episodes of care, this also functions protectively to alert colleagues to the potential for particular residents to engage in such behaviour.

"I will sit with them and some of the girls say 'so and so do this' and 'so and so do, you know, put his hand". (rhec9(f))

This carer subculture may also be understood as an example of workplace resistance (Hodson 1995), in which information and perspectives that may not be deemed relevant or appropriate at an organisational level are expressed and validated. Prasad and Prasad (1998) argue that such routine forms of resistance have the capacity to redefine the nature of the work undertaken and associated authority relationships in the workplace. Despite the clear importance to relations in care of these unsanctioned and often less readily observed forms of knowledge (Archibald 2003), to date there is little understanding of this aspect of care as work.



At a wider organisational level, little observable provision existed for sexual expression by residents in a manner that may be considered either acceptable or permissible, raising the question of what options are open to residents other than to repress their sexuality. This lack of provision may also be understood to indirectly heighten the likelihood of inappropriate expression with implications for staff providing care. The variant responses, given by care workers, demonstrate a lack of standardisation as to how sexuality is treated or understood within care settings. Overall, the responses indicate that dementia serves to trigger the regulation of sexual expression.

### Sexuality: Conclusion

This analysis has highlighted the need to move beyond a current focus upon sexual expression to consider the multiple dimensions of sexuality and their relevance to dementia care. This includes recognition of sexuality as an integral component of personhood.

At present, what is known of the sexuality of people with dementia in residential care is based largely upon proxy reports by a younger and mainly female workforce. It appears that the majority of care workers define sexuality according to how it impinges upon them, and the work they do, demonstrating the extent to which they are often personally implicated within the accounts they offer. Consequently, there is a need for direct attention to the experiences and perspectives of residents and where possible, an elicitation of their own accounts.

Data from this study, alongside existing evidence, suggests that sexual expression is ascribed meaning according to a gendered dichotomy. Masculine transgression can provoke a punishing response, including discharge from a home or removal to other areas of a care facility. Both in research and care practice there is a pressing need to understand the outcomes for residents of interventions that seek to regulate sexual expression. The focus of concern upon feminine vulnerability renders women's sexuality invisible. Women



with dementia often attract a protective response, underpinned by an assumption that they would neither welcome nor benefit from sexual relations. The lack of consultation between carers and residents regarding sexuality maintains these generalised assumptions.

Particular attention has been paid to descriptions of the sexuality of people with dementia residing in care. In an endeavour to explore the status of these accounts and to question what kind of knowledge they offer, an attempt has been made to consider the variety of factors influencing their production. It seems there is a need to disentangle the multiplicity of perspectives and concerns that are embedded within these accounts.

## CONCLUSION

There is a 'permanence' to gender, both as an ever-present aspect of identity throughout the lifespan and in its seemingly pervasive presence across a host of settings and social situations as a means by which social relations are organised. However, both gender relations and gendered identities are open to reconfiguration. Gender has a trajectory in time, not least in the manner that people age in gendered ways. As such, Arber and Ginn (1995) have argued for the need to 'connect' gender and ageing and the importance of paying attention to the differing outcomes for men and women as they age. Such outcomes may be measured at a variety of levels: culturally, structurally, materially and according to embodied experiences of ageing.

However, as Hearn (1995) has argued, exploration of the interaction of gender and ageing has progressed unevenly. There is a dearth of attention to experiences of ageing for men and in the conceptualisation of ageing and masculinity, despite the potential that a focus upon older men holds for disrupting dominant and hegemonic forms of masculinity. Hearn argues that in the social imaging of ageing, older men are:

"... relatively redundant, even invisible, not just in terms of paid work and family responsibilities but more importantly, in terms of life itself" (page 101, 1995).



Through an attention to gender and home, it was found that the lack of any developed notion of an association between masculinity and the domestic sphere has an important bearing upon evaluations of men's ability to cope in care. Interviews with care home staff revealed that a disassociation of men from the homespace is invoked in order to account for both positive and negative experiences of care settings for men. That men are rarely considered 'at home' therefore underpins assumptions regarding their experiences of entry to care. This finding highlights the importance of considering how gender and ageing connect in place and the need to pursue an understanding of how gendered relationships to place alter over time.

Questions therefore arise as to how gender identities may be reconfigured following entry to care. It has been argued that the potential to express and maintain a social identity is tied to the 'salient resources' readily at hand in order to achieve this (Reed et al 1998). The importance of social relations in mediating access to these resources has been highlighted. Thus, the regulation of residents' occupation of space and the social divisions this upholds may be understood as a key influence upon their interactions with, and control of, the physical environment in which they live. As such, the politics of care are an integral feature of the landscape of dementia care settings.

The notion of gender mobility has been suggested as a means to articulate the manner in which gender is situated - socially, spatially and temporally. Thus, individuals not only age in gendered ways but are placed (and displaced) in ways that are mediated by gender and with outcomes that differ according to gender. The manner in which gender is consequently subject to change and reconfiguration according to a trajectory through time and place is what constitutes gender mobility.

An attention to gossip in care has highlighted how these trajectories are navigated, at an interactive level. Gossip was found to provide an opportunity to express and explore a vista across time and place and to make reference to a series of selves and relationships located across these dimensions in support of a social identity. While, at an observed level dementia appeared to disrupt this practice, membership of a group wherein a variety of



impairments were managed at a shared level served as a buffer to the potentially isolating impact of the condition. This observed experience therefore highlighted the social value of friendships in care. The potential erosion of the 'assets' for social exchange occasioned by memory loss and communicative impairment were therefore at least partially counterbalanced by group association. The constrained opportunities on offer for men to develop similar networks of support within residential care highlight one aspect of the differing experience of care for men and women and the social outcomes of this.

The manner in which sexual expression is filtered through discourses of dementia while organised by gender provides a clear example of how particular places produce experiences of gender, while at the same time gender is productive of experiences of place. Masculine and feminine sexuality are read and responded to differently within dementia care, while both are subject to being judged, according to a medicalised discourse, as symptomatic of dementia and therefore requiring surveillance and regulation. Thus entry to care involves a reconfiguration of gender identities and gender relations that is tied to context. This fluidity of gender underscores what may be understood as an experience of gender mobility and again highlights the value of connecting gender and ageing in place.



## 10. CONCLUSION

This concluding chapter is organised into four main sections. Firstly an overview is outlined with consideration given to what this study offers to the current debate on dementia and care for people with dementia. Secondly, some reflections are offered on the experience of undertaking the study, and its status as a piece of work conducted in the context of a wider project. Particular attention is given to the influences that both shaped and placed limits upon the study as it unfolded. An account of the process and outcomes of the study is then given according to its two organising themes: hierarchies and interactions. The utility of these notions in structuring the study is considered alongside a discussion of what each offers to an understanding of social relations and dementia care. Finally, consideration is given to what the findings offer by way of a snapshot of residential care and their implications for care policy and practice.

### Overview

Drawing upon a variety of sources and employing a range of analytic approaches, this project has demonstrated that gender has a patterning influence upon social relations in a residential dementia care setting. Paradoxically, this is despite an overall inattention to the identities of individual residents within care settings. Encounters between staff and residents revealed patterns of contact shaped largely by a requirement to undertake care tasks. The exclusion of a desired social engagement on the part of residents, and any consequent potential to support a social identity, may be viewed as an active accomplishment in care settings, rather than an omission. In the absence of any observed concern to attend to or explore the identities of residents it appeared that the influence of gender existed in an embedded or sedimentary fashion, receiving little deliberate or explicit attention within the care regime.

Nonetheless, this study suggests that gender is indivisible from an experience of dementia with the importance of gender to a workable notion of Personhood therefore underscored.



Consequently, the study exposes an inconsistency within the current debate on dementia. An uncritical use of the unifying category of 'people with dementia' obscures the divisions and differences that are a feature of this diverse population. Gender is therefore usefully understood as veiled by current discourses of policy and practice. An outcome of this has been a gender-blind development and structuring of provision.

This outcome echoes what seems a wider tendency to construct key aspects of welfare policy and provision as gender neutral. Unified notions of the family, community and citizenship and on-going discussion of various social problems have signally failed to address their gendered composition or impact. As discussed, a deconstruction of these terms has demonstrated the exclusions on which each has been built and the manner in which inequalities and difference have been obscured discursively and consequently upheld at a concrete level. It would therefore appear that in this respect, dementia care is representative of the wider field of welfare provision.

This study serves as a critique of constructions of dementia that have actively avoided gender issues. It has shown that various standpoints exist that challenge the assumptions underpinning a generalised notion of 'people with dementia'. Attention to the person with dementia as gendered (and sexual) undermines this homogenisation, exposing the elision that characterises current thinking.

Concurrent with an engendering of the debate on dementia has been an interrogation of gender as an organising category. In this respect the field of dementia care has proved a useful arena from which to address a wider discussion of care. An attention to gender has proved a crucial feature of the unfolding debate on care as a social activity. Gender has been invoked to explain who does care, and why and how care is done. As such it both rules in and out certain ways of understanding care and caring relations. Thus, a deconstruction of 'gender' in the debate on care has highlighted the omission of an array of inequalities and differentials.



At present, it seems an attention to gender in care is centred upon women and to a far lesser extent upon men. The quality of gender as a relational category has therefore been underplayed. That gender may be a fluid social experience, underpinned by interactions and negotiations between individuals has been less often explored. However, the present study considers a changing, movable experience of gender, and gendered relations, that is tied to such negotiation. The various forms and dimensions of mobility that interact with identity lay open to question a reliance upon gender as a fixed and static factor, not least when investigating care.

Within this study, attention has been given to care as a situated practice. Emphasis has been placed upon the significance of local resources that exist to construct identities and configure social relations. In light of this, the importance of viewing 'care for others' as distinct from 'network' caring relations has been suggested. Attempts to theorise and evaluate paid care from findings generated by the investigation of familial caring situations have therefore been questioned. At present, it seems the boundaries to the relevance of studies of informal care have not been recognised, leading to generic notions of care that overlook the specific relations in the domain of paid care. The present study has therefore added to the currently limited evidence that informs a conceptualisation of paid care both as a distinct form of care and as a field of employment that interacts with wider caring commitments.

A focus upon the narratives of care offered by care workers has proved a useful means by which to interrogate both aspects of methodology and the insights such accounts offered of care settings. Carers' accounts presented a perspective upon care according to their own standpoint, revealing their knowledge as situated and as contingent upon the nature of their involvement and activities as workers. By highlighting the dissonance between differing sources of data, the parameters to each source of data have been thrown into relief. A view of interviewing as a particular type of social performance thereby prompted insights into the constructed and constructive quality of carers' narratives. Importantly, analysis revealed the manner in which carers were implicated in their portrayals of the care setting. At present, there is scant consideration given to the conditions under which



care workers produce their accounts of care settings and the work they do. This study has therefore underscored the need for critical attention to such influencing factors when seeking insights into caring relations.

### Influences

An array of benefits was associated with undertaking this study as part of a larger investigation of communication and dementia care. The sheer scope of the wider study, the volume of data generated and the on-going support and co-operation of the host organisation were all at a level that an independent project would have struggled to achieve. The context also set clear parameters to the investigation of gender relations. My autonomy as a researcher with a distinct research agenda was bounded by an association to a wider investigation and crucially, the focus upon communication provided both opportunities and restrictions upon an investigation of gender issues. A number of factors combined to limit the extent to which this study has proved a rounded investigation of gender relations in dementia care.

#### Men and care:

The comparatively low number of men recruited to the CPCEC project proved a challenge to the present study. A key issue was how to set about exploring the presence of a gendered organisation of social relations with associated outcomes in circumstances where men were under-represented. Alongside this concern were the limits set upon the opportunity to address masculinity in care despite the overall lack of work in this field.

Existing research highlights the absence of men from studies of ageing and a wider inattention to the masculinity of older men. The limited attention given to the perspectives of formal care workers has similarly overlooked men's experiences as providers of care. As such, a number of potentially enlightening gender issues have remained largely outside the orbit of the study. However, in undertaking this study the importance of further investigation has been demonstrated on various fronts. It has been argued that care is an



institution in which femininity has been constructed and debated. According to this debate men's experiences have been argued to differ but there has been little further exploration of what this entails. Within residential care, women predominate, it is clear therefore that care for people with dementia represents a useful opportunity to consider the experience and outcomes of a minority status for men.

The findings of this study demonstrate the importance of giving separate consideration to men in care with implications not only for care policy and practice but also a wider debate upon masculinity. Entry to care clearly restricts access to and availability of many of the resources that have traditionally been viewed as empowering men. Factors such as the status associated with employment, unequal access to economic and material resources and the authority and authorisation that men enjoy within a range of public domains are all arguably lost or compromised within residential care settings. Men have traditionally relied less upon symbolic capital, or a sense of self that is tied to this. As this study has demonstrated, in the absence of material resources, the opportunity to maintain a social identity and sense of self at an interactive level is of crucial importance for residents in care. The possibility that men and women arrive in care differently equipped and positioned to exploit these opportunities requires further consideration.

Throughout their lives many men have benefited from the on-going provision of personal services (as distinct from care work) by women, and have been further supported institutionally through what may be considered the 'dividends' of masculinity in patriarchal institutions. It is therefore important to consider what forms masculine privilege takes within residential care. Also, to question how men experience the reconfiguration of gender relations in care settings and what ageing and disablement mean to a hegemonic masculinity. There is a need to further explore the ways in which men utilise the resources available to them in care to uphold a sense of self and establish networks of support in environments where constraints are placed upon the relationships available to them.



Within the debate on care it has been argued that feminine norms and measures have emerged in the conceptualisation of care. Thus an understanding of giving care has been constructed largely according to feminine situations and perspectives. The findings of this study support the worth of giving separate consideration to men who undertake paid care. Not only does it appear that men are called upon to do care differently from their female counterparts - their engagement with care recipients shaped by their gender, but their presence also creates a differing gender dynamic. An exploration of the perception and reports of sexual expression offered a clear example of this. It therefore seems a useful focus for further investigation to explore the wider differences in men's accounts of caring relations.

This study has highlighted the on-going assumption of the natural caring abilities of women, not least as evidenced by the limited training and support on offer to care workers. At the same time it has been argued that care workers import into care a 'personal contract' that reflects their network caring experiences. This finding suggests the importance of consideration of what this means for men, as carers, whose informal caring experiences are likely to differ from women and for whom there is no assumption of an ability to care. It is relevant to ask what experiences equip men to care and how this experience may shape differing approaches and meanings of care. An attention to the 'heavy' and 'authority' narratives of male carers suggests that men derive meaning from their working experiences in a manner that differs from women as carers and view masculine attributes as significant to their presence in care settings.

#### Women and men with dementia:

This study is also characterised by an overall absence of direct input from people with dementia. This was an unintended outcome of the CPCEC project. Efforts were made to interview all project participants and each attempt generated a response from the participant involved. However, for some this response was at an exclusively non-verbal level, whilst for others, a disparity between interviewer and interviewee regarding a sense of time and place proved difficult to overcome. An interview technique also generated



obstacles to the inclusion of participants in the project. A concern to ensure privacy led to interviews being conducted in participants' rooms, the outcome of this was that interviewees were required to call upon their short-term memory when answering questions about the care setting, which proved difficult for many. On occasions when responses to questions differed markedly from observations, there was also the concern that interviewing placed pressure on participants to cover their gaps in memory.

The interviewing experience for the CPCEC project therefore highlighted the inadequacy of this technique when seeking to investigate the lives of people affected by dementia. It pointed clearly to the benefits of the observation and filming that formed part of the project but also signalled the need for innovation in qualitative research methods for this group. The general lack of success of the interviewing also held implications for an investigation of gender issues in care.

Increasingly, the overall lack of direct input from people with dementia to research is being highlighted as a particular concern. The problems associated with reliance upon proxy accounts have been further demonstrated within this study, not least with regard to an understanding of sexuality and sexual expression in care. As such, little is currently known of how people affected by dementia make sense of residential care, what aspects of the environment and the support they receive are valued by them or how they perceive this support. An experience of dementia also represents a unique challenge to wider debates on identity and social relations. What it means to uphold a sense of self and a social identity in the face of an increasing loss of memory, and communicative impairment raises a host of questions regarding what is often taken as 'given' in much discussion of identity. If identity is considered to exist and be upheld relationally then it is pertinent to consider the implications for people whose capacity to engage socially is increasingly compromised. It remains open to question in what forms a gendered identity survives as dementia progresses.

Another key issue highlighted by the experience of interviewing was the impact of an altered sense of time and place and associated with this of a sense of self in time and place



for many people with dementia. A number of participants signalled the belief that they were at an earlier point in life, sometimes still living at home with a parent or in the early stages of adulthood. On one occasion, when I played back a film of an interview that I had conducted for one participant, she was shocked by the image of the older woman she saw on tape. Such an experience suggests a radical form of 'dis-location' for people with dementia as a sense of self shifts across time. A key outcome of this changing self-perception was the suggestion of a bifurcated identity that emerged for many project participants. An embodied identity that forms the basis of how an individual is socially perceived and treated seemed to be dissonant with the internal or imagined identity for many of the people with dementia we encountered throughout the study. Such an experience also appears to have important implications for care practice. If a concern exists to support a sense of self through care it is relevant to question whose notion of 'self' is attended to when such a bifurcation of identity exists.

#### Interactions of care:

As part of the investigation of communication and care an important concern for the CPCEC project was to elicit, from workers, accounts of their experiences and perspectives on care. Responses to these questions proved a valuable resource to the present study in exploring this gendered (and racialised) field of employment. However, the interviewing did not provide an opportunity to explore in depth the lives of workers outside their employment. Clearly this had implications for the present study and the discussion of gender and care.

A review of existing literature has highlighted the importance of encompassing the interconnectedness of paid and unpaid care work. Network caring responsibilities have been shown to have a crucial influence upon women's lives in relation to issues such as health, economic and material circumstances and career advancement. As previously noted, network care also provides a resource by which carers develop a personal contract in their work and a notion of 'ideal' care that they struggle to achieve. It is therefore a limit to the present study that a fuller account of this imbricated experience of care has not



informed the discussion. It remains poorly understood the ways in which differing care commitments are balanced, how they may hold differing meanings for care workers and what continuities exist across these domains of care.

Evidence from the present study highlights the demographic specificity of independent sector care workers. As previously noted this raises questions regarding the viability of disentangling 'race' and gender when investigating formal care. However, it is also clear that the field of dementia care offers a key site for an investigation of gendered experiences of mobility and the implications this holds for the configuration and maintenance of transnational relationships and caring commitments. The motivations and experiences of migration according to gender raise a number of important issues with regard to the interactions of differing forms of care, when commitments and responsibilities are upheld over distance. It also seems that a better understanding of transnational caring relations holds implications for attempts to conceptualise care and the importance of deconstructing a unified notion of 'woman' in the debate on care in light of a migratory experience.

### Organising themes

As an exploratory investigation of gender issues in dementia care this study has delved into various dimensions of the care setting and has employed a number of analytic approaches in seeking to demonstrate the presence and influence of gender in a variety of forms. From such an endeavour the layered or multi-dimensional quality of gender has emerged. A particular challenge in accounting for this undertaking has been the need to draw together and organise the findings and to find ways of denoting the relationships between them. The study has therefore been structured by two organising themes: hierarchies and interactions. A third theme of mobility has emerged as of particular relevance to the groups and experiences explored during the study.

#### Hierarchies:



A hierarchical structure denotes the organisation of power relations. Thus, an attention to hierarchies has proved a useful means by which to explore the influences of and upon gender as a socially organising category of identity. Within the study, hierarchies have been considered at a discursive level and in relation to the concrete outcomes of this ordering of identities. Across a number of domains and institutional settings, gendered inequalities have been discursively veiled, often due to an endeavour to emphasise consensus and commonality in the representation of social relations. This exclusion of gender issues serves to uphold hegemonic standpoints. It is therefore clear that gender is a key concern in revealing the mechanisms and outcomes of power in society.

#### Identities in care:

In the opening analysis for this study, attention has been given to the social, historical and cultural context of relations in care. Emphasis was placed upon the discursive construction of identities and the implications for social relations. The veiled or embedded status of gender was highlighted, for example as a subtext in organisational representations of Jewish Care's service users. Certain key terms were traced across historical narratives of the Jewish community, welfare policy and the organisational context of Jewish Care. The organising influence of unified notions of community and family was shown to have a variety of outcomes for social relations in care. As such, the study has demonstrated the connection of systems of representation to concrete outcomes for lives in care.

A key feature of hegemony is the manner in which it functions to support social hierarchies. Through an exploration of the normative influence of an orientation to family and familial relations it has been argued that care settings attend to and cater for certain gendered identities and experiences unevenly across the population of residents. An important feature of this being the manner in which authorised norms generate notions of what is considered acceptable and healthy. The 'compulsory heterosexuality' of care settings suggests that the presence of non-heterosexual residents is often overlooked, but when identified they seem more likely to be deemed transgressive and disruptive to the social order of care homes. These findings highlight the importance of attention to the



social politics of care. At present, research in the field of dementia care largely omits consideration of how identity serves to organise power relations or the privilege associated with proximity to a hegemonic standpoint. The implications of minority status in care have been overlooked through a failure to recognise the diversity of the population affected by dementia.

A further dimension to the ordering of identities in care, highlighted by the study, was the manner in which a care regime appears to support identity unevenly, at an individual level. An inconsistency was therefore revealed with regard to how Jewish Care explicitly seeks to support a Jewish identity whilst overlooking the sexuality of residents. Similarly, it has been argued that the relevance of gendered biographies to an experience of care receives limited formal recognition, despite the significant influence of gender upon the lives and histories of Anglo-Jewry.

#### Cultures in care:

This study has indicated the presence of three distinct but overlapping 'cultures' within care settings. It has been argued that institutions support hierarchies through the authorisation of particular standpoints and systems of representation. For this reason these overlapping systems may be understood as ordered according to an unequal degree of institutional recognition and support.

The analysis of care files offered an opportunity to explore the ways in which the authority of a medicalised regime was discursively achieved. The representation of disruptive or transgressive conduct as disease symptoms was supported by their decontextualised presentation within files and the unequal access and input to these documents. Thus, textual conventions underpinned the facticity of medicalised labels. Descriptions of sexual expression as 'disinhibition', and resistance to the enforcement of care as 'aggression' were upheld through an absence of reference to the situational or relational context in which residents earned these labels.



It has been argued that a dominant medicalised regime structures the relationships of care workers and residents. The lay-out and headings of care plans and files both reflected and upheld a hierarchy of labour and care practices. The primacy of bodywork and physical care tasks was supported by the detailed manner in which these were monitored and recorded in care settings. There was little evidence to suggest that a comparable system of checks and measures existed for the undertaking of more social and relationship-oriented forms of care.

An attention to reputation provided a useful means by which to explore the layers of representation that operate in care settings. It was argued that residents earn a reputation that is shaped by care routines. Those aspects of a resident's identity and conduct of most relevance to these routines often emerge as the salient features of their public reputation. In addition to authorised and formal representations, a less visible carer subculture also functions to classify and categorise residents. It was argued that a carer subculture represents a (gendered) form of workplace resistance, highlighting the importance of recognising carers' status as workers and the influence of employment relations upon caring relations. To date there is a marked absence of attention to this aspect of care work, despite its potential significance to an understanding of paid care as distinct from informal care.

A case study of friendships in care revealed the presence and workings of a resident subculture. The interactions of residents also served as a site for the construction of reputations in care, the interpretative resources employed by residents were formulated outside of a medicalised discourse, reflecting a differing set of values and beliefs. There was little evidence to suggest that a dominant medicalised regime attended to this resident subculture or recognised its significance to the lives of residents. Despite their clearly beneficial influence upon life in care, there were no observable mechanisms in place by which care settings sought to facilitate or uphold friendships. Indeed, in a number of respects care settings appeared to impede resident relations.



This study has suggested that friendships provide opportunities for upholding a sense of self and serve as a buffer to the isolating effects of illness and disability. The nature of interactions between residents stood in marked contrast to the imposed mode of communication that appears dominant in care. The analysis of interactions between residents offered an insight into the variety of ways in which identity may be upheld at an interactive level and it was argued that gender mediates this process. The lack of existing research that addresses residents' relationships, outside of an attention to their contact with care workers, undermines an understanding of how such relationships may be facilitated and enhanced. There is little appreciation of the insights such friendships offer into residents' perceptions of the care setting or the influences of a resident subculture upon the conduct and well-being of residents. The present study has generated evidence of the skills and strategies that residents employ to maintain meaningful relationships in residential care.

#### Interactions:

A theme of interaction has proved useful to this study at a number of levels. It has served as a metaphor by which to connote the connections of gender to a range of relational categories of identity and to aspects of social experience. Thus, a process of interaction signals the manner in which identity is configured through such connections and the limits to an understanding of gender as an 'add-on' in the investigation and representation of social relations. This study has sought to trace interactions of 'race', immigrant status and class with gender and thereby to question how useful or viable it is to disentangle these factors analytically. The study has highlighted the elisions performed by a focus upon the category of gender, in the debate on care. Embedded within constructions of gender within much existing research is a middle class, white perspective - one that is neither old or disabled.

However, there remains a need to theorise these interactions and their specificity in the domain of formal care. Dementia care has proved a useful site within which to demonstrate that Black women have a differentiated and particular experience of



providing care, not least where racism emphasises the 'otherness' of workers in relation to those for whom they care. As a racialised and gendered field of work, dementia care also lends itself to a wider consideration of how Black women experience both institutionalised and interpersonal forms of racism and discrimination in ways that may differ from the experiences of Black men.

A theme of interaction also points to the fluid and negotiated quality of identity and social relations, and the manner in which this unfolds at the level of communication and social discourse. Video data have highlighted the interactional form of a number of concerns that are central to this study. It has been argued that both dementia and care are usefully understood as relational and dynamic. Similarly, while gender has been shown to pattern interactions it has emerged as a co-constructed and negotiated aspect of identity. The study has highlighted an apparent inconsistency whereby despite this patterning influence, at an observed level there appears to be few opportunities to explore and express gendered identities within care settings. For both workers and residents, gender appears subsumed by care-based practices and forms of communication.

#### Dementia:

In common with the wider project within which this study has been undertaken, an attention to interactions in care has proved an invaluable means by which to explore constructions of dementia. It has prompted an attention to the mechanisms of communication in care. In contrast to a biomedical model that locates communicative impairment at an individual level, anchoring a capacity to communicate within a disease narrative, it has been shown that care regimes dictate both the opportunities to interact and the nature of that interaction. This finding supports a view of dementia according to a social model of disability.

However, to date, the experience of dementia has not been encompassed by a debate on disability and as such, there has been little consideration given to how dementia may lend itself to the theorisation of disability in socio-political terms. This study suggests that



people with dementia are denied the opportunity to socially engage and when they do, find their attempts to communicate devalued or overlooked, thereby highlighting the interactional dimension to disablement. The struggle to maintain social relationships and a sense of self through these relationships seems compromised by an enforced social isolation and a host of strategies that maintain an orientation to care tasks during encounters between care providers and recipients. Such findings thereby signal the value of an attention to dementia care to a wider debate upon disability.

The study has questioned current constructions of Personhood, highlighting the need to consider how Personhood is maintained in gendered ways. The process of maintaining Personhood appears compromised by the loss or inaccessibility of salient resources. It has been argued that these losses impact in ways that differ according to gender. A further inconsistency has therefore been highlighted in which care settings appear to undermine residents in their struggle to support a sense of self through restricting the availability of resources and activities that might support biographical narratives.

#### Care:

Video taped data showing episodes of care unfolding in real time have proved useful to an understanding of care. It has been argued that a focus upon care-giving has shaped the conceptualisation of care in a manner that obscures its dynamic quality. During episodes of care the experience of providing and receiving unfold simultaneously with both parties making active (but unequal) contributions to the encounter. Such a perspective highlights the value of understanding care as a fluid and negotiated social event. The present study therefore makes a useful contribution to the debate on care, providing evidence of this dynamic whilst highlighting the importance of gender to this process.

It has been shown that caring relations are managed in gendered ways. A gender boundary has an organising influence upon the acceptability of personal care and the presence of men in care settings. The patterning of care according to gender thereby leads to differing experiences and outcomes for both carer and caree. Gender is called into play when



providing care and the response to care-giving also takes on gendered forms as residents resist a task-based focus and the enforcement of care tasks. Crucially, gender also provides a framework for making sense of episodes of care. It has been argued that gendered norms and assumptions serve as interpretative resources when offering accounts of caring encounters.

A gender boundary also highlights care as an embodied activity that shapes the nature of work undertaken and what individuals are called upon and expected to do. Both workers and residents in care have a bodily presence that is significant to their experience. It has been argued that the communicative challenges associated with dementia care heighten the significance of residents' bodies, both as barometers of subjective experience but also as the surfaces upon which a nexus of organisational and caring concerns and imperatives are inscribed. As such, embodiment is constructed discursively, in a manner that reflects the priorities and culture of the caring regime. An analysis of the body as a contested site in care highlighted contests for control but also signalled the manner in which gender is done to residents and upheld through care practices.

#### Gender:

Analysis of caring interactions also served as an opportunity to elaborate an understanding of gender and communication. Within much existing sociolinguistic analysis, gender has been treated as a static variable, viewed as underpinning styles of communication and differing forms of speech. The present study has demonstrated the interactive operation of gender in episodes of care. It was found that gendered labels fulfilled strategic purposes during the provision of care, that gender created a dynamic between interactants in a manner that influenced the meanings attached to the content of encounters, and that it served to script interactions. The presence of a gender boundary signalled the manner in which gender also underpinned the rules of engagement in care settings. These findings support a notion of gender as fluid, indicating that it is open to negotiation at an interactional level but also demonstrate how care settings serve to configure gender relations.



A dementia care setting also offered as an opportunity to explore the situated forms of gendered communication. The manner in which care-speak appeared to subsume gendered differences in communication, highlighted the importance of attending to communication in context and the limits to generalised models of gendered interaction. A case study of a group of friends residing in care highlighted that patterns of association are upheld in gendered ways.

### Mobility:

For the participants of the present study, mobility has been highlighted as a key feature of social experience. Mobility occurs at a number of levels and is a useful descriptor of concrete experience and as a metaphor for the changing and fluid quality of identity and social status. Individuals move between places with consequent experiences of displacement and placement, while differing domains and social settings offer local resources for an expression and maintenance of identity, serving as collective sites of gender configuration.

Existing studies have argued that gender is overlooked in the accounts and representations of migration. Experiences of mobility have been conceptualised according to a masculine norm, this despite clear evidence that migration is patterned by gender. As noted above, care appears to be an important influence upon women's migration while at the same time migration shapes the caring relationships they maintain. To date, little consideration has been given to the significance of mobility to experiences of gender and how such movement serves to reconfigure gendered identities and gender relations.

Similarly, there appears to be a dearth of attention to the ways in which social mobility is negotiated and experienced in gendered ways. As the present study has highlighted with regard to the Anglo-Jewish community, social mobility appears to have an important bearing upon the expectations and experiences of women and men. The upward mobility of certain sections of the Jewish community is characterised by differing outcomes for



men and women that are organised according to the gendering of a public/private divide. The lack of consideration given to gender relations, including the negotiations between men and women has thereby underplayed the manner in which social mobility interacts with fluid experiences of gender.

Experiences of transition to care have received attention within existing research although, remarkably, there has been limited consideration given to the ways in which gender mediates such relocation. The present study has highlighted the manner in which gender organises the accounts offered by care workers and their perceptions of the differing meanings of this transition to women and men. A significant aspect of these accounts was the association of gender to place and the manner in which gender is perceived as producing experiences of place. An assumption of the disassociation of masculinity from the home highlights the importance of further attention to men's experiences of the homespace and the manner in which this relationship alters over time.

Mobility may also be taken to connote a passage through time and a social experience of ageing. Thus, a parallel debate within social gerontology that appears relevant to an understanding of fluid experiences of gender is the call for attention to a connection of gender and ageing. It has been argued that the meanings attached to gender at an individual and wider social level are not constant over the life course. This study has provided the opportunity to explore an experience of ageing according to a gendered trajectory in time. An attention to life histories discussed by residents has highlighted the importance of recalling these experiences in support of a sense of self in care. While supporting relationships in care, such narratives also offer an insight into the fluid experiences of gender over time and the manner in which older people are uniquely placed to account for this given their biographical vista.

This study has placed emphasis upon the interaction of identity and place and through this signalled the contextualised or situated construction of gender. For example, an attention to constructions of sexuality as organised by gender, whilst read according to the presence of a biomedical model of dementia, has highlighted this localised representation of



identity. The analysis underscored the manner in which placement in care leads to a reconfiguration of identity and social relations and thereby the fluidity of experiences of gender. The notion of gender mobility has therefore been introduced in an endeavour to describe the connection of trajectories through time and between place and their shaping influence upon identity.

### A snapshot of dementia care

In the final section of this concluding chapter an effort will be made to draw upon findings to offer a snapshot of dementia care. Emphasis will be placed upon the opportunity this study gives to offer a critique of the care regime and the implications for lives in care. In so doing the discussion will seek to highlight how an attention to gender has served to produce certain perspectives and insights.

The care regime:

Arguably the most significant finding of this study, echoing a theme across social research in the field of dementia, is that care provision is oriented to dementia as the primary attribute of service users. There appear to be few other aspects of an individual's identity and social experience that are consistently given attention or upheld in a systematic fashion.

An inattention to the social identities and biographies of residents renders dementia the over-riding motif of their reputation in care. It has been argued that the presence of dementia serves as a crucial interpretative resource in making sense of the conduct and identities of residents. Dementia takes on the quality of a global state for residents, wherein little of their day to day contact with care workers is motivated by anything other than an input of care tasks. Furthermore, the observed absence of consultation with care recipients suggests that dementia is a construct of the care setting, imposed upon residents rather than premised upon attempts to derive personalised knowledge of an individual.



## Care documentation:

"When a resident comes into a home you get this social worker's report and that's about it, it's limited, you know, is that what this person is all about? The 80 or 90 years, just those few pages and that's it, you want to know a lot more, it would be nice to have a little life history as they come into the home, but social workers don't do that." (rhbc20(f))

Analysis of care home documentation highlighted the manner in which care files served to organise and hierarchise knowledge in care settings. The descriptions and accounts of residents in care files offered an insight into a prevailing culture of care. The facticity of entries was achieved in a number of ways and validated by a medicalised logic of a disease experience. The present study has suggested that certain 'symptoms' are relationally produced, shaped by the input and actions of care workers often under conditions where a task-based agenda contrasts with a desire for social engagement on the part of residents. The value of dynamic models of both care and dementia is therefore highlighted.

An attention to gender has proved illustrative with regard to the social construction of symptoms and the subsequent importance of attending to how representations of residents are 'worked up' in care settings. The presence of gendered norms and assumptions as an organising influence upon the production of accounts of sexuality and sexual expression underscore that such accounts are interpretations determined by standpoint. A differing response to the sexual expression of men and women illustrates the medicalisation of these social norms and assumptions within care settings. The manner in which symptoms appeared to emerge as an interaction of identity, conduct and third party evaluation highlights the instability of these medicalised labels, their uneven application signalling an absence of any clear consensus as to what they purport to signify.

The absence of direct input from residents into care files served to rule out alternative readings or versions of events. This finding also highlighted the absence of mechanisms by which residents with cognitive or communicative impairment were supported in participating in the structuring and provision of the care they received. As such there



appear to be few opportunities for residents to define themselves. Little consideration is given to what residents consider the purposes of care, or how they would prioritise their needs. The only alternative input to files, other than from paid workers, were occasions when the views and evaluations of relatives were elicited. There appeared to be no provision made for independent advocacy for residents who did not have families.

An analysis of constructions of sexuality provided a useful means by which to demonstrate the limits associated with proxy accounts, and how they invoke the imposition of meanings. Such imposition is shaped by the situated knowledge of care workers based upon the nature of their relationships with residents and the constraints placed upon their interpretations as a result. To date, research in dementia care has paid scant consideration to how such second-hand accounts of the experiences of people with dementia residing in care are mediated by social difference, with implications for the status of the knowledge that is subsequently generated.

Care files were found to have a crucial influence upon the provision of care. Their contents not only dictated what was known of individual residents but the information and personal detail they failed to gather led to significant gaps in this knowledge. For example, an inattention to the sexual needs, histories and identities of residents contributed to the lack of recognition for this area of their lives, other than when it impinged upon care practice and disrupted the social order of care settings. This finding demonstrates the manner in which a partial knowledge of residents has direct outcomes for their experiences of care.

The care environment:

Attention to the physical environment and lay-out of homes signalled their importance for social relations in care. The type and arrangement of furniture was observed to inhibit interaction between residents at both verbal and non-verbal levels. Residents had access to few resources that offered engagement or occupation outside of a reliance upon care workers and activity co-ordinators. Little provision existed within care homes for residents



to enjoy privacy or to spend time away from the surveillance and regulation of care workers.

Residents were regulated in their use and occupation of space and their movements within each home were restricted both by physical barriers and the interventions of care workers. Those who required assistance to mobilise, moved around the care setting less, and exercised less choice as to where they sat and with whom. Rarely were occasions observed when residents left the confines of the units in which they resided. Despite growing attention to the design of dementia care environments and an accompanying concern for the disabling influence of care settings, there has been little consideration given to the strategies that residents themselves employ to overcome this, for example through a strategic use of space. An attention to friendships in care has suggested that these strategies may also be mediated by gender.

The overall inattention to the biographies of residents undermines an awareness of what might represent salient resources in care or what activities and experiences may support the biographical narratives of individual residents. The significance that various activities may hold to residents appears overlooked as care workers seek to undertake tasks and maintain social order in a manner that restricts resident participation in many aspects of the day to day workings of care settings.

The present study has suggested that the maintenance of a sense of self and a social identity is linked to gendered practices. Gender is therefore a mediating factor in how wider biographies serve to shape experiences and coping in care. It was found that little consideration is given to the manner in which men and women may experience the care environment in differing ways or be faced by differing challenges within it. This despite the gender imbalance of care settings and the consequently differing coupling constraints placed upon men compared to women. Interview data revealed that few care workers deemed the presence of male carers as significant to the social opportunities for men in care.



There remains little understanding of how women and men cope with entry to care outside of an imposed logic of a gendered public/private divide. Or, of the (gendered) ways in which residents find meaning in their day to day experiences despite the paucity of resources and opportunities for social engagement that characterise life in care. As the present study suggests, inattention to gender leaves open to question the manner in which gender differences may lead to disadvantage.

The care routine:

An attention to routine care practices highlighted a number of issues with regard to a prevailing culture of care. The input of care was found to be ordered according to levels of dependency. The social identities of residents appeared marginal to such routines, supporting a view of dementia as a global state in care. Residents were offered few opportunities to exercise choice in the timing and provision of care and episodes of care were observed to unfold according to a pace set by workers.

The medicalised focus of documentation was observed as carried forward into day to day interactions, with little concern shown to explore the identities of residents or generate personal detail. The employment of 'care-speak' served to actively restrict resident input to episodes of care, subsuming personalised forms of communication and thereby signalling the importance of viewing formal care as distinct from informal care.

The care-speak genre of communication was argued to serve a number of purposes in care settings, not least in respect to the efficient completion of tasks. However, a clear outcome of this form of communication is that care provision is routinely undertaken across a population of residents characterised by a marked variation in levels of capacity and functioning. Little evidence was generated to indicate such variation was taken into account, suggesting the presence of generalised assumptions regarding residents' support needs. Such generalisation supports an understanding of dementia as relationally imposed given that the routine input of care appeared to have limited association with an experience of the condition at an individual level.



As the current study attests, an overall lack of formal recognition or attention to social identity is belied by the manner in which gender patterns social relations in care settings. It has been argued that gender norms and assumptions play a key role in the processes by which residents were represented and their conduct and actions accounted for. Such assumptions appeared to shape interpretations and were imposed upon residents in ways they seemed ill-equipped to resist.

This study has drawn attention to a host of distinguishing factors that render dementia care a distinct field of caring with particular implications for both service users and care providers. The cognitive and communicative impairments that characterise dementia and the consequent vulnerability of many service users highlights the importance of attention to the specific needs of both workers and service users. These findings serve to challenge the current lack of specific attention given to dementia in legislation and policy.

An attention to accounts of emotion at work has highlighted not only the particular skills that carers employ but also the emotional costs of dementia care work. Of particular note was the impact felt by workers of struggling and sometimes failing to make sense of the attempts to communicate by the people with whom they work. At present it seems that there is limited opportunity for care workers to reflect upon their practice, or occasions when they may seek support from colleagues or raise issues of concern. Such conditions support a contention that women's 'natural' ability to care remains an assumption that underpins care work.

### Questioning care:

For many people with dementia, residential care may offer the most suitable environment for their continued care. It is an option that represents a potentially less isolating and safer setting in which the provision of healthcare is of a standard and quality that compares to and may even excel that on offer from community-based services. Undoubtedly, residential care offers a solution to family carers who may be overwhelmed by the



enormity of caring for a person with a progressive condition, requiring increasing input and support. The impact upon the health and well-being of family care-givers is often a significant factor when placing a person with dementia in residential care.

Such considerations are crucial to an overall evaluation of residential dementia care. However, the present study has touched upon a number of features of such care settings wherein there lies a need for change. Based upon the findings of this study, it seems that care settings and an associated culture of care are disabling to people with dementia. If it is accepted that key concerns when caring for a person with dementia include support in maintaining a sense of self and a social identity and opportunities to uphold a degree of biographical continuity, this study makes clear that institutionalised care is failing service users.

At present, limited personal knowledge of an individual informs care, raising the question of what logic informs the selection (and exclusion) of information imported into and made use of within care settings. Of the information that is generated, the efficacy of how it is currently presented and utilised is open to question. Of the information and opinion that is gathered and recorded why is it that currently so little concern is shown to disentangle the perspectives and interests of contributors or to question what stake they have in the accounts they offer?

Why is it that assessments and the insights they generate are not anchored in time and place? In what way do assessments or third-party reports reflect the changing and fluid experience of a progressive condition? And, to what extent do they account for the influences of the methods used to investigate a person's situation and perspective, thereby reflecting the dynamics of their production? Why is it that so few mechanisms exist that seek to directly include the perspectives of people with dementia in the provision of care? When a person with dementia struggles to communicate why are the methods of eliciting their input not seen to be at fault?



Beyond this it seems important to question what theories underpin and guide dementia care. Neither in policy or practice is there currently reference made to a notion of Personhood in relation to people with dementia, let alone any debate regarding the limits to this concept. At present, the most positive forms of support to people with dementia exist at the level of care. However, the care settings under investigation for the present study showed little evidence to suggest that social models of illness and disability actively influenced the systems governing the administration and provision of care.

This study suggests that, beyond medicalised models of care and health, a wider debate on dementia has yet to make inroads into practice. As a result, a great deal of what is known about people with dementia residing in care is shaped by how this information supports care routines. Under such conditions it appears that conduct that impedes care tasks is often deemed transgressive. Anxiety is generated when the order of care settings is threatened. It remains open to question what this implies for residents whose distress is expressed in non-disruptive forms.

An attention to gender has proved a useful means by which to explore the disruptive effects of care upon identity and biographical narratives. However, at present there appears to be little debate on what changes to care practice would be required to promote person centred. The deflection of attempts of residents to be involved in the running of care settings and a lack of consultation with them seems to overlook the damaging effects of over-accommodation. Furthermore, care environments revealed little evidence suggesting that a notion of environmental disability influenced a concern for the lay-out and use of space.

Current research in the field of dementia care is characterised by an absence of attention to the perspectives and experiences of paid care workers. Little is therefore known of how carers are positioned to make sense of what happens in care settings. Whilst the Care Standard Act (2000) calls for a larger proportion of workers to have relevant training, it seems there is currently little understanding of the manner in which training is operationalised in day to day care provision.



Whilst the completion of care tasks is both monitored and recorded, the social aspects of care appear poorly attended to. Carers indicated a tension between what they perceived as ideal and actual care provision, contrasting instrumental aspects of their practice with socially and relationship-oriented forms of engagement. The question therefore arises of what principles underpin care when such competing concerns clash?

The study found that (often challenging) aspects of care work receive limited recognition at an organisational level and that little formal guidance exists with regard to issues such as the management of sexual relations or challenging abuse and discrimination. Under such conditions, care workers are required to intervene and act according to their own beliefs and evaluations. It seems that an outcome of this is that situations are handled in a manner that is potentially inconsistent, while care workers are positioned to take personal responsibility for their actions. This often takes place under conditions where a host of demands combine, not the least of which being a concern to balance individual needs with that of the collective.

The frequency of having to face ethically challenging dilemmas in dementia care work was also highlighted. Miscommunication and misunderstanding led to occasions when residents were resistant to care, presenting individual workers with the dilemma of how to negotiate such situations. At present it seems that such dilemmas are often resolved at an individual level, with little formal guidance and the absence of a clear protocol on how to proceed. One question this raises is whether it is either advisable or acceptable that workers should make such decisions, regarding the ethics of their practice, in situations that are often emotionally charged and where there is a pressure to complete care tasks within a limited time-frame. Within a regime structured by, and prioritising, care tasks, such ethical concerns appear to compete with rather than underpin care provision.

Within care settings, there seems to be no space for a debate upon the rights and entitlements of people with dementia. There is a pressing need to consider what boundaries exist to the usurpation of responsibilities and to question what right an



organisation has to make decisions on behalf of those in receipt of care. As this study confirms, the surrogate decision-making assumed by care workers stretches beyond daily routines to encompass more intimate and far-reaching issues, often under conditions where a residents potential capacity to make an informed decision is given little attention.

## CONCLUSION

As an investigation of gender relations in dementia care this study has offered the opportunity to explore the gendered features of an institutional setting. Beyond this it has served as an insight into the configuration of social relations in time and place. As such, it has generated what might be understood as situated knowledge. As the preceding discussion has emphasised the study is by no means a full and rounded account of gender relations in care. The overall shape of the study and the contribution it makes to existing knowledge is bounded by an inevitably partial coverage of the situation and setting. Various limiting factors have therefore been acknowledged, these include the opportunities and restrictions that characterise differing methods of investigation. An effort has also been made to pay attention to how the accounts offered by project participants are shaped and limited by their own interests, the nature of their engagement with the care setting and the requirements placed upon them.

However, the study has generated a variety of insights into residential dementia care. A concern to explore a number of common or representative features of the care setting heightens the potential that the findings hold a significance that extends beyond the particular settings under investigation and thereby offer evidence that is useful outside of a localised application. This study of gender relations has made an attempt to explore issues previously untapped by existing research. In this respect it makes a novel contribution to an understanding of an aspect of dementia care that is currently under-investigated and thereby poorly accounted for. With a particular concern to address issues of identity and social relations it also serves to highlight the limits of the systematised workings of a medicalised culture of care. An attention to gender has thereby provided a useful measure



of the significance of recognising the social experience of dementia and the key importance of a sociological framing of dementia care.



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## Appendix 4



Makes caring less of a burden

**EXELON<sup>®</sup>**  
rivastigmine

#### EXELON

##### Prescribing Information

**Indication:** Symptomatic treatment of mild to moderately severe Alzheimer's dementia. **Presentation:** Capsules containing 1.5, 3, 4.5 or 6mg rivastigmine. **Dosage and Administration:** Effective dose is 3 to 6mg twice a day. Maintain patients on their highest well-tolerated dose. Maximum dose 6mg twice daily. Reassess patients regularly. Initial dose 1.5mg twice daily, then build up dose, at a minimum of two week intervals, to 3mg twice daily, 4.5mg twice daily then 6mg twice daily, if tolerated well. If adverse effects or weight decrease occur, these may respond to omitting one or more doses. If persistent, daily dose should be temporarily reduced to previous well tolerated dose. **Contraindications:** Known hypersensitivity to rivastigmine or excipients or any other carbamate derivatives; severe liver impairment. **Special Warning & Precautions:** Therapy should be initiated and supervised by a physician experienced in the diagnosis and treatment of Alzheimer's disease. A caregiver should be available to monitor compliance. There is no experience of use of EXELON in other

types of dementia/memory impairment. Nausea and vomiting may occur, particularly when initiating and/or increasing dose. Monitor any weight loss. Use with care in patients with Sick Sinus Syndrome, conduction defects, active gastric or duodenal ulcers, or those predisposed to ulcerative conditions, history of asthma or obstructive pulmonary disease, those predisposed to urinary obstruction and seizures. In renal and mild to moderate hepatic impairment, titrate dose individually. Safety in pregnancy not established; women should not breastfeed. Use in children not recommended. **Interactions:** May exaggerate effects of succinylcholine-type muscle relaxants during anaesthesia. Do not give with cholinomimetic drugs. May interfere with anticholinergic medications. No interactions were observed with digoxin, warfarin, diazepam, or fluoxetine (in healthy volunteers). Metabolic drug interactions unlikely although it may inhibit butyrylcholinesterase mediated metabolism of other drugs. **Undesirable Effects:** Most commonly (>5% and twice frequency of placebo): asthenia, anorexia, dizziness, nausea, somnolence, vomiting. Female patients more susceptible to nausea, vomiting,

appetite and weight loss. Other common effects (>5% and >placebo): abdominal pain, accidental trauma, agitation, confusion, depression, diarrhoea, dyspepsia, headache, insomnia, upper respiratory tract and urinary tract infections. Increased sweating, malaise, weight loss, tremor. Rarely, angina pectoris, gastrointestinal haemorrhage and syncope. No notable abnormalities in laboratory values observed. **Package Quantities and price:** Basic NHS Price: 1.5mg x 28 £31.50 4.5mg x 28 £31.50; 1.5mg x 56 £63.00 4.5mg x 56 £63.00; 3mg x 28 £31.50 6mg x 28 £31.50; 3mg x 56 £63.00 6mg x 56 £63.00. **Legal Classification:** POM. **Marketing authorisation number:** 1.5mg EU/1/98/066/001-2; 3mg EU/1/98/066/004-5; 4.5mg EU/1/98/066/007-8; 6mg EU/1/98/066/010-11. **Date of preparation:** January 2001. Full prescribing information including Summary of Product Characteristics is available from: Novartis Pharmaceuticals UK Ltd, Frimley Business Park, Frimley, Camberley, Surrey, GU16 7SR.

**NOVARTIS**

EXE 00/30g



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*To make a donation, please call Jewish Care on*

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**Appendix 6: (Coding schedule for Analysis 1)**

Res.Code		Home		Date		Tape.no.	
Tape length - From:				To:			
Actual period of analysis							
Number of interactional episodes							
No. with Researcher							
No. with 'others'							
No. with carers							
Of which - carer initiated							
Task based							
Social/relationship							
Of which number of snap shot							
Number of resident initiated interactions ignored by carer							
Duration of all interactional episodes							
Duration of all carer initiated interactional episodes							
Duration of verbal interaction							
Number of wholly silent contacts							
Routines:							
Cleaning - times:							
Meals - times: B'fast:				Lunch:		Supper	
Medication - times:							
Organised Activities - type:				Duration:			
Gender - number of contacts with male carers:				Number of contacts with female carers:			
Environmental Factors:							
Media:							
Seat layout							
Notes:							



**Appendix 7 (Coding schedule for Analysis 2)**

<b>Tape no.</b>	<b>Res./home code</b>				<b>Actual period of anaylsis:</b>
<b>Start:</b>	<b>Res. Appears:</b>				<b>Ends:</b>
<b>Gaps:</b>					
<b>Initiated:</b>	carer	resident	other	who	
<b>Content:</b>	nv/tb	v/tb	nv/sr	v/sr	nv/c
	v/c				
<b>Duration:</b>	<b>Duration of verbal content:</b>				
<b>Gender of interactant:</b> male    female					
<b>Tone:</b>	neutral	positive	negative		
<b>Res input:</b>	elicited	maintained	curtailed		
<b>WIB</b>	+3	+1	0	-1	-3

--	--	--	--	--	--

<b>Initiated:</b>	carer	resident	other	who	
<b>Content:</b>	nv/tb	v/tb	nv/sr	v/sr	nv/c
	v/c				
<b>Duration:</b>	<b>Duration of verbal content:</b>				
<b>Gender of interactant:</b> male    female					
<b>Tone:</b>	neutral	positive	negative		
<b>Res input:</b>	elicited	maintained	curtailed		
<b>WIB</b>	+3	+1	0	-1	-3

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## Appendix 8

Two female care workers approach a drowsy, diabetic male resident with the intention of taking blood. The sequence lasts for 2 minutes and 45 seconds. c1 = female care worker, c2. = female qualified nurse (indicated by colour of uniform), r. = male resident.

Underlined words = emphasis in intonation.

### Verbal

### Non-verbal

1. c1. - Peter, hello, hello, Peter can I take you to table please	1. C1. - approaches resident and kneels in front of him, she takes hold of his hand and leans her face towards his. C2. Is preparing a syringe at a table to the residents left.
2. c2. - Peter, can I have a little	2. C2. - approaches resident from his left side and bends towards him
3. c1. - Peter, we've got to take a little bit of blood, don't jump okay, I'm holding you, alright, it's only a pinch, okay, don't jump	3. C1 - grasps resident's right hand and touches him under the chin, the resident's head is slumped forward
4. c2. - I just want to get some <u>blood</u> /c1. - a little bit of blood, just a little bit of blood	4. C2. - takes hold of left hand and puts needle to skin, resident flinches
5. c1. - <u>oops</u> , okay, okay, okay	5. Resident pulls away, sits forward and pushes the hands of both carers away with closed fists
6. c1. - hold on, hold on, hold on, alright, alright, alright, <u>alright</u>	6. C1. - takes hold of right hand again, kneels forward raising herself slightly
6. c1. - Peter/c2. - I just want some little blood, Peter, can I have it? Uh ah	7. C2. - takes hold of left hand. C1 - maintains grip on right hand and leans across to hold left wrist of resident.
7. c1. - <u>ooh</u> , okay, okay, alright, alright	8. Resident pulls both his hands away and swings his arm out, he hits c1 on her upper arm twice with the flat of his hand. He then slumps back in the chair with his head forward
8. Brief (inaudible) exchange between c1 and c2	9. C1. - stands up, walks to the right of the resident and stands slightly behind him, she leans forward over him and takes hold of both his wrists.
9. c1. - Peter/c2. - Peter, he's very strong, he's holding my hand, <u>stop it</u>	10. C2. - takes hold of resident's left hand and resident grips her right hand
10. c1 - Peter, there's lots of blood on me/c2. - I know, you'll have to wash it properly/ c1. - I know	11. Resident struggles to release himself, c1 - takes hold of both wrists again, c2. - takes hold of right hand
11. c2. - <u>oow</u>	12. Resident pushes c2. away then kicks her on the knee while gripping her left hand, she tries to pull away while



<p>12. c1. - oh, get the, <u>ow</u>, he's <u>so</u> strong, <u>Peter</u></p> <p>13. - c1. - Peter, stop it please/c2. - that's it (pause) right, there, that's it</p> <p>14. c1. - finished, finished, finished</p> <p>16. c1. - finished, finished, finished, finished</p> <p>17. c1. - look at this blood/ c2. - you better go and wash it</p> <p>18. c2. - fourteen point five, it's fourteen point five, he can have the insulin today</p>	<p>holding his lower left leg with her right hand</p> <p>13. C1 - grips resident's right wrist with her right hand and places her left arm around his neck while gripping his left wrist below his chin</p> <p>14. C2. - moves round to resident's right side, her back is to the camera and she obscures the view of the resident (successfully takes blood)</p> <p>15. C1. - pats resident on shoulder, he slumps over with his head forward</p> <p>16. C1. - pulls resident upright in chair by the shoulders and strokes his right arm</p> <p>17. C1. - holds out arm to show blood and then turns and walks away, c2. - moves away from resident</p> <p>18. C2. - looks at sample of blood and walks away</p>
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Appendix 9 - Deflections

The following episode of interaction was recorded in the main day room of a residential care home. Twice a day (usually at about 10.30 a.m. and 3.00 p.m.) a tea trolley was wheeled into the room and three to five carers would pour and hand out tea to residents where they sat. The trolley would remain in the room for approximately ten minutes on each visit. Four carers are handing out tea to residents seated in the day room at 3pm in the afternoon. The interactions recorded take place between two female residents (r1 and r2) and two female carers (c1 and c2). Total duration = 9 minutes.

Verbal	Non-verbal
1. r1. - "Shall I help you dear?"	1. Resident 1 leans forward in her chair to catch the attention of the carer pouring tea at the trolley, which is sitting in the middle of the room.
2. c1. - "No thank you darling"/ r1. - "thank you very much dear" (Pause of two minutes)	2. The carer responds without looking at resident 1 and continues to serve tea. Resident 1 sits back in her chair.
3. r2. - "Let me help you please"/ c2. - "She doesn't like help"	3. Resident 2 sits forward to offer help. Carer 2 also responds without looking at her.
4. r2. - "Bless you my dear"	4. Carer 1 hands resident 2 her tea and then continues to serve other residents.
5. c1. - "Sit down Lou"/ r1. - "Yes, I wasn't going to stand up, I wouldn't" (Pause)	5. Resident 1 sits forward in her chair and half rises to her feet, she then sits back down.
6. r1. - "Would you be a good girl and call me if you need me?"	6. Resident 1 leans forward in her chair and tries to attract to gaze of the carer.
7. c1. - "I don't need you dear" / r1. - "Alright love". (Pause of three minutes while resident 1 sips her tea in silence)	7. The carer responds without making eye contact. She then walks forward and hands a cup of tea to resident 1.
8. r1. - "Thank you very much dear, when you do any ... can I"	8. Resident 1 stands and approaches the trolley holding her empty tea cup, she hands it to the carer.
9. c1. - "Yes, can you sit down for me please"	9. Resident 1 turns and walks back to her seat and sits down.
10. r1. - "Can I, may I ... no ... just" (Pause)	10. Carer 2 walks past as she is serving tea, resident 1 leans forward and starts to talk to her as she approaches, the carer continues walking and ignores the resident.
11. r1. - "Do you want me to get any?" / c1. - "No, no, no"	11. Carer 1 returns to the tea trolley, as she does, resident 1 leans forward and stands up, she points at the tea trolley as she offers to help. The carer responds without making eye contact.



## Appendix 10

2.45 in the afternoon - Pam, Jan and Edith are seated in the foyer following a visit to the mobile shop in another area of the home.

Edith - What a load of rubbish

Pam - It's not for me anyway, I want to try it on

E - I'm surprised with it, I'm really disgusted with it

Jan - What did they think we were? It's just a lot of schmutters, a load of schmutters

E - I'm ashamed, I'm surprised at (name of care worker who booked the shop)

J - Well, she didn't know what they were going to bring

E - I thought I'd see a nice, oh ...

J - What a load of rubbish, me, I wouldn't touch it

E - I didn't see a thing

P - (to Jan) - did you go round?

J - No, not a thing there worthwhile, I just glanced

E - I didn't even go near them, old rags

J - Those dresses, what a disgrace (pulls face)

E - Oh my life (waves hand)

J - We would have been better off going to the club

E - Now I'm upset

J - Oh, I am, load of old tosh, not one dress

(Pause in conversation)

J - What a load of tripe

E - Oh it was shocking

(Muriel joins the group carrying a bag)

E - You bought something?

Muriel - A dress, there was only one I liked

E - I didn't go near, I didn't go near them

J - Me either, I didn't touch them (waves hand), load of tripe

(Pause in conversation)

J - It looked like a jumble sale didn't it, shame, we could have gone to the club

E - I didn't go near anything

J - I just picked up a few jerseys to see if there was any sleeveless cardigans but there was nothing, but apart from that it was a load of tripe (waves hand)

(Pause in conversation)

J - The dresses were like rags, oh gawd. Last time they were quite decent, last time they came there was something to look at, oh.

(Pause in conversation)

J - I looked, I saw, I turned (pause). It looked like um, what do they call those shops? They looked secondhand to me

(Pause in conversation)

J - Oh what rubbish, didn't you think so?

P - Oh yes, not for me, I've got better dresses at home

E - I'm very disappointed

J - I know we're old but ... I say, I know we're old (waves hand)



The conversation then continues in bursts, the subject of the shop interwoven with a range of other topics. The last mention of the shop is at 5.05pm.



## Appendix 11

Jan (to researcher) - She never talks very much, the only thing she'll ask me is, um, when's supper time and I have to tell her about a thousand times.

Invitee - Who's this?

Jan - Muriel. What's the day, is it Saturday, Sunday or Monday and I say no darling ...// ... well you see she goes up so many times, she asks me what the day is, she doesn't know it's Saturday and I have to tell her

Researcher - Right

Jan - And then she goes, she says 'I'll try and get (name of daughter) back, and she'll try and get these daughters umpteen times through the day

Researcher - Right

Jan - And I'll usually say to her well they're at work but today I couldn't be bothered and I never mentioned it when she said she was going up to get (name of daughter), but I thought, you now, I don't think the girls are very happy because she tries to get them so many times on the phone ....// ... She can change jumpers three or four times a day

Invitee - It's a pity he (referring to researcher) wasn't with us when we went out. We went to a show yesterday and she went with (name of carer). She was sitting in the front row, wasn't she?

Jan - Right in the front

Invitee - And they had had them facing her all through the show

Jan - And she was crying

Invitee - She was crying, she can't bear anyone to be happy, it was terrible...//

Jan - We thoroughly enjoyed it but poor Muriel - no. She was putting her fingers in her ears. Now a little while back we went to a pantomime and she was sitting next to me. 'I'm going out, it's too loud, I'm going'. I said, you can't darling, you can't go out all on your own and I don't want to go out and miss the show, you'll have to put up with it and she was flinching and miserable. She's a very, very sad lady

Invitee - She is a sad lady, she cries. I had a session with her a little while ago, she coming over to my table, (to Jan) it's true isn't it (Jan nods). 'Why won't you be my friend' 'What have I done to you?' And that's what she's shouting

Researcher - Right

Invitee - she makes people miserable.



## Appendix 12

Jan - My poor mother used to say I was the most miserable child to have on holiday because I would never play like the other children on the beach, because I couldn't go on the beach without my shoes on, because I couldn't bear the sand on my feet. I couldn't touch the sand because I couldn't bear it going down my nails. My poor brother, he was everywhere, as soon as we got there he'd made friends, not me, I used to sit there 'oh I can't touch this, can't touch that' (grimaces). I never went in the water that's why I stopped my son from swimming, because I was so frightened of the water I never encouraged him to go in the water. When I was at the seaside I used to say 'well you don't need to go in the water' and I sort of stopped him and that's why he couldn't swim. And then, when he went to school unfortunately he slipped and cut the back of his head, you know where it gets wet, and from then on he wouldn't go swimming. So he had me to thank for not teaching him. But he's taught himself to swim a little bit, since he's got older. And my granddaughters are such good swimmers, all three of them because he was so determined that they would do what he never did. So he had them taught. But my poor mother wouldn't let me go swimming because she was worried I'd get pushed in. She was always worried I'd get pushed in the water, so she wouldn't let me go.



## Appendix 13

A relative arrives to visit a resident and stops to greet the group. Edith recognises her from the synagogue she used to attend and after the relative moves on the group work collaboratively to 'locate' her socially.

Edith - I didn't know that was Mildred's niece.

Jan - Mildred's niece, her husband, Mildred's husband and her husband are uncle and nephew and she's the wife, so she's the wife ...

Edith - I have seen her at the shul, I must say ...

Jan - Her husband is Mildred's husband's nephew, well Mildred calls him her nephew as well, but he's on Mildred's husband's side

Pam - Who was that young woman who came?

Jan - Her daughter is the tall one, the tall girl, that's her daughter

Pam - She's a very nice girl as well

Jan - She's friendly with Lucy's nephew, the one who comes here



## Appendix 14

Pam and Jan invite another resident to join them and they discuss another, absent, resident's family to whom the invitee is related:

Jan - What's the daughter's name?

Invitee - Julia

Jan - How old is Julia?

Invitee - I don't know, she must be 28, 29 or 30, I don't know, I think she's the oldest of the children

Jan - How many children has Beryl got?

Invitee - Three, two boys and Julia. I'll show you a photograph from when one of her son's, Karl got married. You know the girl who helps in the hairdresser, does the shampoo - she's a friend of Beryl's son's wife.

Jan - Oh

Invitee - You know what, because she had a surprise on the first day we went up there and she was going to shampoo my hair and she said 'excuse me, do you know Karl (surname)?'

Jan - Oh yes

Invitee - I said yes, because she'd noticed my name in my cardigan when I took it off to have my hair washed. She's a great friend of Beryl's son's wife, from the wedding, they're great friends.

Jan - Oh, I've got you, well I never

Invitee - Well, I'd never met her because I don't see very much of that side of the family at all. So when I was ill and I couldn't go to the hairdresser's, she sent down a message

Jan - Oh. Now, they're on your husband's side aren't they, on your husband's side?

Invitee - Yes

Jan - Now those cousins from Eastbourne who came up the other day, who's family are they? Your mother's?

Invitee - From Eastbourne?

Jan - Was it Eastbourne? Whose cousins are they?

Invitee - They're my first cousins on my mother's side

Jan - On your mother's side - oh.

Invitee - Mother's side, yes. They're the ones I gave the candlesticks to, I'm glad I gave them to them, so they're in the family, but they're not so well off. Well, he's been very sick, since he was a little boy

Jan - Oh yes, you told me



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